The American Journal of

NURSING

[illegible] AUGUST, 1930 Number 8

# Radium, Redon, Radiumtherapy

ANNA L. GIBSON, R.N.

[illegible] is the chief member of [illegible] series of radio- [illegible] belonging to [illegible] group of elements. [illegible] of pitchblende and [illegible] The radium salts of com- [illegible] white or greyish powders [illegible] more or less brightly in [illegible] can be [illegible] However, there are [illegible] found in [illegible] The [illegible] About [illegible] and Marie Curie succeeded in extracting from pitch-blende two new elements, polonium and radium. In 1899, Danlos commenced studying the effects of radium rays on certain skin lesions; and in 1906, Henri Dominici set forth the principle of ultra-penetrating radiation.

It is generally the duty of the nurse to make up all applicators used in radium therapy, therefore she should familiarize herself with the physics of radium. To obtain a clear comprehension of radium one must know something about the atom of which all matter is supposed to be formed. The atom is a very complex structure made up of small units and is an exceedingly small piece of mech- [illegible] A drop of water contains several [illegible] million atoms and within the atoms are the much smaller electrons pursuing orbits, like planets, around the sun. The atom, therefore, consists of a minute nucleus made up of positive and negative [illegible] Ac- [illegible] all ele- [illegible] though they [illegible] chemical and physical properties, are built of the same material, namely, positive and negative electrons, and assuming that these are the only two constituents of atoms, the difference between one atom of radium

[illegible] lead cylinder containing the radon tubes in the center of a roll of [illegible]

[illegible] treatment of the spleen and of deeply situated tumors.

[illegible] in thickness.

[illegible] of the spleen in leucemia. The lead box U containing the [illegible] been fastened to the top of the frame T.

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[illegible] of lead, etc., is merely [illegible] and ar- [illegible] the substance in the [illegible]

[illegible] peculiar prop- [illegible] and in [illegible] unknown [illegible] of the [illegible] is a [illegible] are [illegible] a [illegible] days that [illegible] light and heat [illegible] itself very [illegible] called [illegible] or radon. The [illegible] that 1,750 [illegible] required for half a [illegible] of radium to disappear.

## Radon

[illegible] or radon is a [illegible] and it too [illegible]

deposit themselves on anything and everything that comes in contact with the radon, including the walls of the receptacle that contains it. These substances transform themselves much more rapidly than radium itself does. Half a given quantity of radon disappears in 3.85 days; half a given quantity of Radium A, in 3 minutes; Radium B, in 26.8 minutes; Radium C, 19.5 minutes, and so forth. The radon may be extracted from the radium element and pressed into a glass or metal container of any desired shape or size and the Radium A-B-C allowed to accumulate in it. Professor William Duane of Harvard has devised a machine for collecting and purifying the radon, and this method has been adopted by the leading institutions in the United States which have large amounts of radium. The manipulation of the radon is a highly technical process and necessitates the services of especially trained assistants whose measurements of its initial radioactivity and its subsequent variations can be relied upon. Radium in quantities less than a gram does not lend itself readily for radon purposes. Small quantities of the element are [illegible] put into platinum [illegible]

[illegible] of radon is no [illegible] the radium element [illegible] from the element [illegible] in the [illegible] the number of [illegible] during [illegible]. The [illegible] unit of measurement in which quantities

[illegible] Epilation from the Radium at Distance

[illegible] negative electron moving [illegible] high velocity; gamma rays [illegible] of high [illegible] to x-rays but are [illegible]. These three rays [illegible] penetrating power. If [illegible] radium or radon is placed [illegible] [illegible] filter for this [illegible]

gamma rays. These filters or screens of heavy metal give rise to secondary radiation, so it is necessary to use a thin layer of aluminum, adhesive plaster, or several layers of wet gauze to remove the secondary rays.

In expressing dosage when applying radium rays, the quantity of radium or radon employed is stated, the screening, if any, the distance of the applicator from the growth, the distribution of the radioactive material over the surface of the growth, and the time of the application of the radium. Where a method of application is standardized, dosage is expressed in terms of the product of milligrams of radium or millicuries of radon used and the number of hours it is applied, the product being the so-called milligram or millicurie hours. Thus 200 mg. of radium applied for 5 hours gives a dosage of 1000 mg. hours.

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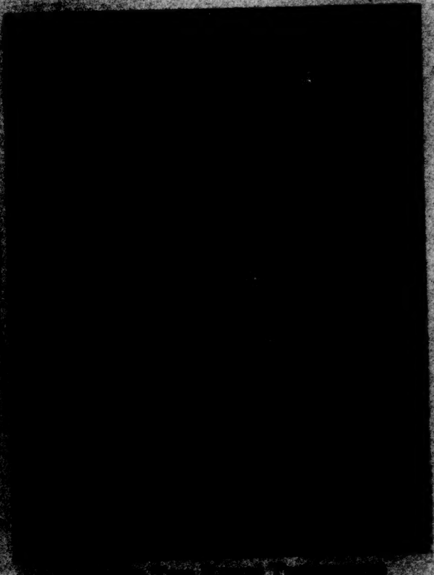
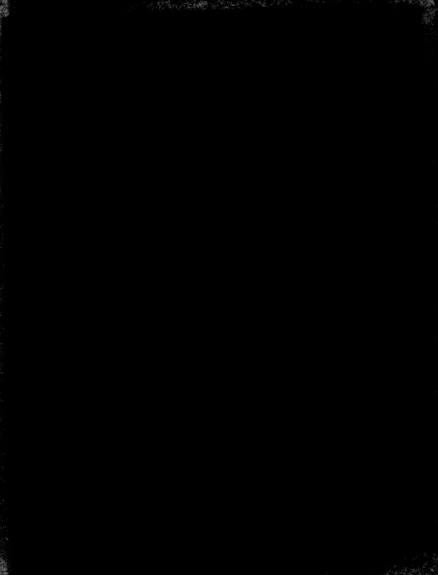
[illegible] are sterilized [illegible] and [illegible] by moist or dry heat.

[illegible] Care

[illegible]



[illegible] Lesion entirely healed three months later



[illegible] the dressing will be found an excellent deodorizer. Nausea and vomiting may be relieved by giving small [illegible] of iced ginger ale or sodium [illegible]ate.

[illegible] can make themselves [illegible] sources of authentic information with respect to the prevention, [illegible], and care of cancer cases. [illegible] have an unusual [illegible] for detecting early cases [illegible] recogni[illegible] to an in[illegible] and by exerting an in[illegible] these cases they [illegible] them to seek [illegible] treatment. [illegible] that treat[illegible] may be [illegible] too small [illegible] rather than [illegible] or lack of care in [illegible] may penetrate

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[illegible] "A Clinical Index of Radium
[illegible]

[illegible] by radium.

## The Public Health [illegible] for August

*Official Magazine of the National [illegible] Public Health Nursing*

[illegible]

[illegible]

A [illegible]
[illegible]

# Cancer of the Breast

## [illegible] Sphere of the Trained Nurse in Detecting It

BURTON J. LEE, M.D.

[illegible] occupies an important [illegible] position in the prob- [illegible] the control and care of [illegible] breast. Many women [illegible] hesitate to seek medical [illegible] turn for advice to the [illegible] her opinion as a final [illegible] the matter. A responsi- [illegible] should not assume may fall [illegible] decision, and the advice [illegible] given may determine the [illegible] patient. Social service [illegible] increased her contact [illegible] patients. The oppor- [illegible] afforded the well in- [illegible] to teach other women in [illegible]

[illegible] can give useful informa- [illegible] proper-fitting and [illegible] and stays. She [illegible] to teach that [illegible] and those of compres- [illegible] to normal breast [illegible] been shown that [illegible] may lead to chronic [illegible] of the breast (mastitis) [illegible] may be a factor in [illegible] of mammary cancer. [illegible] of the supporting [illegible] the individual. [illegible]

Many women suffer considerable pain in the breast just before or during menstruation. Usually these symptoms are of little significance, but occasionally they prove to be of importance. Patients with these conditions should be directed to seek competent medical examination and advice.

The nurse should teach other women that any symptom referable to the breast requires an examination by a physician. Every tumor of the breast is potentially a menace to the patient. These cases should be immediately referred to a doctor for diagnosis, for a wise nurse will never attempt to diagnose a condition of the mammary gland. Recently, a patient with an advanced inoperable cancer of breast came to my attention, a survey of whose history revealed that two years previously she had consulted a trained nurse because of a small mass in the breast, and had been assured by the nurse that the tumor was of no importance because it was painless. The fact is that three-fourths of the patients suffering from cancer of the breast have as the first symptom of their disease a painless lump. When first seen by a physician the patient in question was beyond surgery. The disease progressed rapidly, and she died six months later.

The pain may be an early or even an initial symptom of cancer, and some of the most malignant forms of the disease begin in this way. Therefore, malignant disease of the breast cannot be excluded because of the presence of pain.

The nurse should remember that, although cancer of the breast is more often a disease of mid-life or old age,

one out of every [illegible] [illegible]

[illegible] nipple. When Paget's disease [illegible] advanced, it is a serious form of [illegible] of the breast.

The diseases of the mammary gland are [illegible] and difficult to differentiate. Physicians alone have the technical training to [illegible] a diagnosis in this field. All that the trained nurse should do is to guide the patient toward sound medical opinion. If a woman, referred to a physician for diagnosis of a breast condition, [illegible] with the report that [illegible] physical examination [illegible] the nurse may [illegible] ing to the [illegible] advice should [illegible] physician [illegible] of the breast [illegible] advising [illegible] nurse may justly advise the patient to obtain another medical opinion.

Finally, the most important service of all which a nurse may be privileged [illegible] summary [illegible] who have [illegible] to have [illegible] by a [illegible] This [illegible] though [illegible] health. [illegible] cancer [illegible] regular [illegible] and [illegible] rendered [illegible] attempt to [illegible] of the breast.

A [illegible] "Cancer Control—How [illegible] Accomplish- [illegible] New York [illegible] Street, New York.

## Consistency of Foods

O[illegible] nursery [illegible] are some [illegible] invariably [illegible] and [illegible] do [illegible] flavor, [illegible] which the [illegible] vegetables [illegible] the [illegible] to [illegible] consistency [illegible] vegetables [illegible] di- [illegible]

# Student Adjustments[1]

## FLORENCE K. ROOT

[illegible]Y as never before the question [illegible] of the adjustment of the [illegible] to his environment is [illegible] of educators and those [illegible] interested in the progress of [illegible]. So complex is this [illegible] into which we must [illegible] are to maintain our existence [illegible]! Men like Spengler [illegible] for this civilization [illegible] disintegration. We seem to [illegible] something that we [illegible] to stop. I shall not [illegible] with Spengler nor un-[illegible] agree. I am using his [illegible] merely for evidence that [illegible] process of our civilization [illegible] adjustment to it are [illegible] the attention of the great [illegible] today.

[illegible] Beard says:

> [illegible] the meaning and course of [illegible] with re-[illegible] the whole front. No [illegible] about life, [illegible] A sys-[illegible] the very concept [illegible] [illegible] challenge, is [illegible]

[illegible] I want you to [illegible] "Consider what [illegible] of this chal-[illegible] [illegible]

[illegible]

fully a little later. But now we must ask further, Is this physical adjustment, this fitting into the mechanical scheme of things, enough to ensure progress, satisfaction, and happiness?

Lewis Mumford says:

> Plainly, if human life consisted, as the new mechanists suppose, in adjustment to the dominant physical environment man would have left the world as he found it. Man's uniqueness consists in the fact that, since the principle he seeks involves more than his physiological balance, he has created standards and ends and purposes of his own which he imposes upon nature.

Again quoting from Mr. Mumford:

> When Mr. John Dewey says that the salvation of the modern individual lies in making his own chaotic personality conform to the corporate pattern that has been automatically created by modern technology and finance, one wonders if he can possibly be conscious of the defeatism involved in such a position.

That is, according to Mr. Mumford, man can and must create standards, ends, and purposes, that go far beyond the mere adjustment to the physical environment. And that is the second thing that I want you to notice, a creative spiritual energy which transcends the conformity to modern technology and finance.

I have quoted Mr. Beard and Mr. Mumford as a background for what I have to say that we may realize that there is or should be a philosophic foundation for our efforts toward student adjustment, and we should regard it not as a few mechanical devices to make the machinery run more smoothly during the first year of a student's life in college, but as an effort to obtain a sane, wholesome and normal reaction and attitude toward one's immediate environment, and also to start the formulation of a philosophy of life.

How important is this adjustment and how much should be done about it? As I have been thinking about this for the past months I have come to feel more and more that this is very important and that it needs something more than orientation lectures or "Freshman week." And sometimes I fear that our personnel work with its bureaus and records is being caught up in the same machine and I want to insert a little plea for less formal organization. We all are responsible, let's not leave it to one person entirely.

All this talk about education, how little we are accomplishing, et cetera, et cetera. Well, whose fault is it? Not the students' entirely. We must secure a different idea of what education is and how it is obtained. Sometimes I think that it is the older generation which needs adjustment to this high pressure machine age, to which the younger generation takes like a duck to water. But after all that is only the mechanical and superficial adjustment and is comparatively less important. What we want is to build in the mind of the young person the idea that this hurrying, worrying outside world is not the whole of life—that the world of the spirit and its cultivation is of far greater importance.

Too often we make the mistake of thinking that student adjustment is different from that of other young people. That is not the case. Whether it be college or business or profession there comes a time when every young woman is thrown more on her own responsibility than ever before. She generally needs some help. One of the difficulties is that she often does not recognize any lack in herself nor any need and the help therefore must be unobtrusive and anything but patronizing.

When we speak of student adjustment we are apt to think of social adjustment. In reality there are various phases and I want to speak of four of them:

1. Vocational or economic.
2. Intellectual.
3. Social or emotional.
4. Spiritual.

I am afraid I am going to speak from my failures rather than my successes. Getting ready for this talk crystallized my idea of what I want to accomplish rather than what I have accomplished. And from now on I am going to limit my discussion to the young woman from 17 (possibly 16) to 20 who is starting upon this new profession: that is, we are dealing with the later adolescent period. Now is there any one word which can describe that somewhat incoherent state of body, mind, and soul that we find? I believe awkwardness is the key word. The head of our psychology department has been conducting some very interesting investigations of the ordinary problems of students, and he gave me that word, awkwardness, as the keynote.

We are quick to recognize and excuse the physical awkwardness of this period. But this physical awkwardness is quickly overcome and by the [illegible] and [illegible] by the time the girls come into our sphere of influence. But there is an economic, [illegible] and a [illegible] of [illegible] [illegible] the [illegible] The [illegible] [illegible] thinking, in feeling, and in their gen-

[illegible] toward their relation to [illegible] We are not going to bother [illegible] today. But what of these [illegible] in their late 'teens who [illegible] to find their balance and [illegible] the muscles of their minds [illegible] the sinews of their souls [illegible] the flesh of the spirit that [illegible] the hard knocks of life [illegible] be bruised?

[illegible] show as much tolerance and [illegible] toward this inner and [illegible] awkwardness as we [illegible] to earlier physical mani- [illegible] Let us consider it along [illegible] lines which I have mentioned, [illegible] this—not all are awk- [illegible] all the lines. Some may [illegible] a nice balance in cer- [illegible] and be hopelessly awkward [illegible]

*Vocational or Economic*

T[illegible] Freshman is generally quite at [illegible] from the economic viewpoint. [illegible] for money are many; her [illegible] supply, small. Of the many [illegible] upon her by her own [illegible] spending, she doesn't know [illegible] of the most importance and [illegible] She wants so many [illegible] pretty clothes, [illegible] things to eat, movies—the [illegible] is great, the supply of ready [illegible] and because of lack of [illegible] little things loom big. As [illegible] the property rights of others [illegible] trampled upon—borrow- [illegible] you, and [illegible] How can we give her a [illegible]

But what of the adjustment to the larger economic world? How shall I earn my living? There ordinarily the Freshman is hopelessly lost and stumbles awkwardly along, trying now this path and now that, worried and anxious. Here the awkwardness is due to her lack of knowledge both of her own ability and of the fields of occupation that are open to her.

You do not have to meet that problem of vocational adjustment except in the case of misfits for when the student comes to you she has chosen her profession. On the other hand I imagine that you often have to help the student make a quick adjustment between what she has imagined the nursing profession to be and what it really is. And at this point I can give you no advice. I can only take off my hat to you and wish that I could get across to my students the idea of what education in a liberal arts college really is, as quickly as you imbue your students with the professional attitude.

Let me stress the importance of this professional attitude—whether it be nursing or business or teaching—the lack of it so often hinders a girl from the advancement she would otherwise make. We should use every possible means to do away with that bad habit of taking everything personally. I feel that student government and student authority are in no way successful until penalties can be imposed and received without jeopardizing the friendship of those involved and it is valuable in so far as it helps a girl to recognize that she is a part of an organization and responsible for the welfare of that organization.

In the same way the suggestions and criticisms of some older person, someone in authority, may be valuable not only for the immediate reaction but because it should accustom her to

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lege, and not in the lives of many students, but occasionally and imperfectly we achieve something of what we are after and then we know that it isn't a fruitless task we are undertaking. In these few cases lies our great reward, the joy of the work.

Before I stop I want to make a few very practical suggestions of ways and means for making these adjustments. You will notice that I have talked entirely of the normal, average student. I purposely have avoided the cases that demand more than an elementary knowledge of mental hygiene. What we might call the "problem" cases are so widely discussed in these days and their treatment by specialists could be so easily obtained by you through your hospitals, that I have not felt it necessary for me to discuss this.

To return then to the adjustment of the average student and the ways and means of doing this. In this whole matter I believe very strongly in any conferences or committees that will bring the older women and the younger together to talk things over. That division that rose up suddenly between the two generations soon after the war was most deplorable.

I believe that we of the older generation were largely to blame. We were afraid of this lively, energetic, somewhat spoiled and altogether independent group. We feared their criticism and to avoid this I think we were too ready to lower our standards, to condone much because every one was doing it. We were not sure of ourselves. There seems to be every indication now that both groups are seeing the needs of each other. It is much easier therefore for all to work together and I think that any form of dormitory or student government should be cooperative rather than divided. That is the only democratic way.

# [illegible] Common Diseases of the Skin of the Feet

[illegible] HAZEN, M.D., AND FLORENCE B. BIASE, R.N.

[illegible] are two common dis[illegible] of the skin of the feet [illegible] much discomfort [illegible] which there is still [illegible] even among physi[illegible], namely, ringworm [illegible].

[illegible] of the feet and hands [illegible] called to the attention of [illegible] profession of America in [illegible] and Mitchell, and [illegible] it has been generally [illegible] dermatologists. At the [illegible] many of the laity have [illegible] of the disease. A [illegible] names has been given: [illegible], acute eczematoid [illegible] of the hands and feet, as [illegible] blisters," "mud feet" [illegible]

[illegible] is probably the com[illegible] in the world. At the [illegible] of the University [illegible], over sixty per cent [illegible] were found to be [illegible] Leland Stanford the [illegible] even higher. Atten[illegible] called to the fact that [illegible] one of the [illegible] society, for in dis[illegible] is not especially [illegible] private practice a [illegible] of the feet will [illegible] per cent of [illegible]

[illegible]

of the life of the parasite outside of the human body, although it can live for months in dried epithelial scales.

In certain cases the body possesses a considerable degree of immunity against the invader, but one attack does not guard against subsequent ones. Children under eight years of age practically never acquire the disease. The organisms affecting the toes do not attack the scalp nor do they invade the hairs or the hair follicles. Likewise they never affect the face and very rarely the body. The ringworm organisms do grow deep down into the skin, and this is the reason they are so difficult to kill.

In many instances the disease is by no means a mild one. In 161 consecutive cases which we studied, fourteen persons were totally disabled for from two to sixteen weeks, and thirty-two were partially disabled.

A number of clinical types can be recognized: the first is where there are cracks or scales between the toes, with an occasional felt-like pad between the fourth and fifth toes. The second type is where small or large blisters develop upon the soles of the feet, the dorsal surface of the toes or even the ankles. Similar blisters not infrequently develop upon the insides of the fingers or even upon the palms. New crops of blisters may appear at frequent or at infrequent intervals. The third type is where there is a more or less diffuse scaliness of either the palms or soles, combined with a few vesicles. The fourth type is the hyperkeratotic one, with thickened masses of hard dry skin, usually upon the soles. The fifth type is the most severe and in this there are large raw areas with much weeping and oozing.

[illegible] a ten per cent solution [illegible] in equal parts of [illegible], or a three per cent [illegible] violet in alcohol [illegible] is preferred. Between [illegible] powder should [illegible] as the organisms [illegible] to any one drug, it is [illegible] remedy used once in [illegible]

[illegible] the above method of [illegible] ninety-nine per cent of [illegible] cleared up and at least [illegible] cured. Because of the [illegible] the disease, many so- [illegible] are probably rein- [illegible]

### Plantar Warts

[illegible] warts are simply ordi- [illegible] that have developed [illegible] and which have been [illegible] the skin by pressure. [illegible] as frequent as are warts [illegible] are far from uncom- [illegible] in girls' schools are [illegible] and family epidemics are [illegible] For some reason, school [illegible] boys are very rare, [illegible] due to an unknown type of [illegible] auto-inoculable and [illegible]

[illegible] may be either soli- [illegible] As many as sev- [illegible] been encountered upon [illegible] the presence of five to [illegible]

promptly tell the difference, for the wart is much more sensitive.

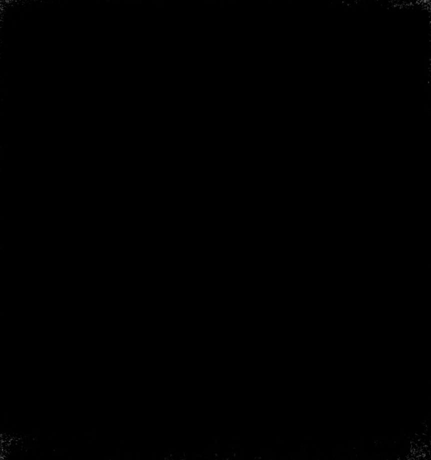
Persons having plantar warts should not use common bath mats nor should they permit others to wear their stockings. They should not go barefooted, but should wear canvas slippers. The method of election for the treatment of plantar warts is either x-ray or radium, and there is little to choose between the two agents, although an occasional wart will yield to radium when it stubbornly resists x-ray. The treatment must be heavy and confined to the wart alone. If the x-ray is employed, no filter should be used; but with radium some filtration is essential.

In the case of multiple warts, where large areas must be treated, it is necessary to employ small doses. One of the most striking effects of x-ray treatment is the relief from pain which usually occurs about five days subsequent to the first treatment. Treatments are given at intervals of four weeks, and from two to three are usually necessary to effect a cure. We have seen no bad effects from treatment, save in one case where a roentgenologist treated a large area too intensively, and a few telangiectases resulted. A protective pad may be worn if it gives comfort, but no medicine should be used upon the wart. Over ninety-five per cent of permanent cures have resulted from this method of treatment.

Excision with the knife results in temporary disability and is followed by a scar. In addition, recurrence of the wart is only too common. Treatment with acid or silver nitrate is very painful and frequently ineffective. The use of the electric spark is painful unless the local anesthetic be very well given and always results in several weeks of disability.

# Saving Labor in the Plaster Room

[illegible] NURSE, R.N.



F[illegible] plaster [illegible] purpose I have adopted a [illegible] board. This board is an ordinary board 30 inches long, 6 inches wide and 1 inch thick, covered with white [illegible]. It provides the necessary [illegible] and may be placed on any [illegible]. Being covered with the [illegible], it is easily cleaned; it is [illegible] to handle and may be [illegible] in a small amount of closet [illegible]. It is especially convenient [illegible] the bedside of a patient [illegible] cannot be moved to the plaster [illegible].

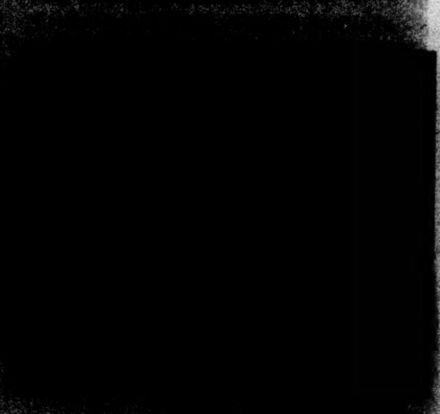
[illegible] made of maroon rubber [illegible] which fit inside the buckets in [illegible] the plaster bandages are dipped, [illegible] and [illegible]-covers. [illegible] should be made a little [illegible] than the [illegible] of the buckets [illegible] enough to allow a cuff to [illegible].

A thorough [illegible] of all the equipment used in the plaster room prevents the plaster from [illegible] to it. This is especially true of the Hawley table, [illegible], knives, etc.

# A Ward Cart

W[illegible] it was found [illegible] [illegible] [illegible] [illegible] the cart.

The cart is made of [illegible] [illegible] equipped with two [illegible] and [illegible] [illegible] eight-inch rubber-tired wheels. The entire frame is painted with [illegible] which gives a [illegible].



# A Venereal Disease Clinic

## *An Experience in Adaptation*

ELLA M. RAFUSE, R.N.

[illegible] aftermath of the war, many [illegible] realized, as never before, [illegible] of venereal dis- [illegible], mental, physical, [illegible] the need to control it [illegible] of the individual and the [illegible] was one of those [illegible] for help to the hos- [illegible].

[illegible] that a hospital in [illegible] was working was [illegible] which became interested, [illegible] experience in the [illegible] worked out somewhat as [illegible]

### *The Project*

[illegible] State Department of Health [illegible] and put through a bill [illegible] for a bonus of $1,000 per [illegible] established hospital or [illegible] in each town of 10,000 [illegible]) which would open and [illegible] clinic for venereal disease [illegible] and prevention. The sal- [illegible] doctor in attendance, a [illegible], was the concern [illegible]. All other expense was to [illegible] the hospital until the clinic [illegible]

[illegible]

also to be the center for distribution of free arsphenamin to such doctors in the community as wished to use it, thus cutting down rates to patients proportionately.

### *The Situation*

THE hospital was a general hospital of 150 beds, and had no outdoor service except a monthly clinic conducted by a Boston orthopedist, under the auspices of a semi-public association for the care of children. The hospital furnished the room and nursing service for the clinic itself. Any patients recommended for hospital treatment were paid for at regular rates by their parents or by the society. Hence the service could hardly be considered dispensary work. This hospital was chosen for the clinic partly because of its success in the above-mentioned clinic and partly because the doctor appointed by the state to take charge of the venereal work approved of its methods.

It was a limited staff hospital, taking all kinds of patients except those usually handled by a contagious service and chronic cases. The staff was permitted to extend the courtesy of the hospital to a few doctors who were, in its opinion, capable and desirable. This arrangement resulted in between fifteen to twenty men and women who sent patients with more or less regularity. Theoretically, at least, it was not a charitable institution. In practice, however, although each patient paid or was paid for, there was practically always a deficit which had to be met by the board of trustees. They were charitably-minded, of course, but they were also business

[illegible] the purpose under con- [illegible]

[illegible] it was thought, could be [illegible] small extra payment per [illegible] supervisor and one [illegible] carry on the clinic [illegible]

[illegible] There also presented [illegible] in a hospital where [illegible] of discarded [illegible] furniture, chairs, ta- [illegible] which had been re- [illegible] them by more mod- [illegible] It therefore appeared [illegible] cover expenses, [illegible] not cost too much to [illegible] building.

[illegible]

[illegible] reasonable that through [illegible]

7. Does the community want it?

The question of the attitude of the community was one of which no one was sure, but the fact that it was forward-looking in child care, school hygiene, milk and food inspections, and so forth, seemed hopeful.

8. Could it be made to include the care of private patients of this group?

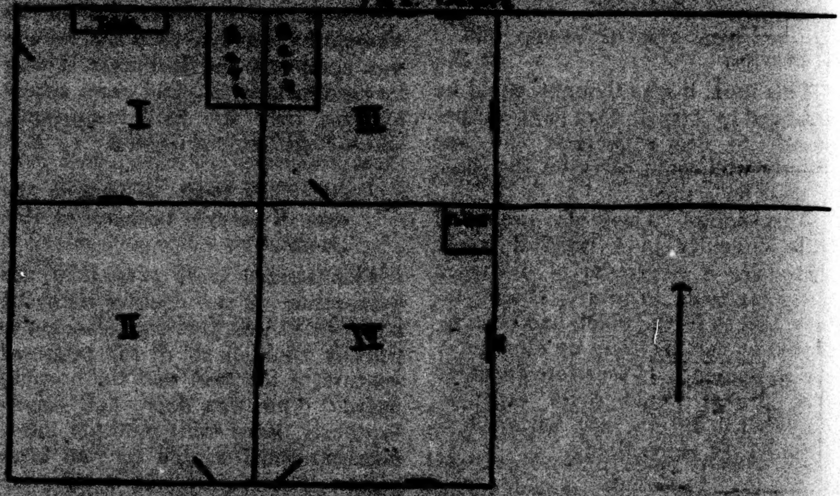
This seemed most possible if the coöperation of the doctors could be secured. It was, therefore, decided to present a statement of the proposed venture to the staff and the hospital board. This was done, and simultaneously, since their monthly meetings happened to fall on the same night. The impact was terrific, because no one had foreseen such a storm of protest. The hospital board objected on two counts:

1. It would involve some expense, for they were sure that there were not enough patients of that type to help to any extent with the finances, since "there could be only a few anyway, and those few of a class which could not pay."

2. They believed that it would ruin the hospital in the eyes of the paying class of patients in the city to have a clinic of such a sort in connection with it, especially since the community would not understand that [illegible], if properly handled, can be [illegible]

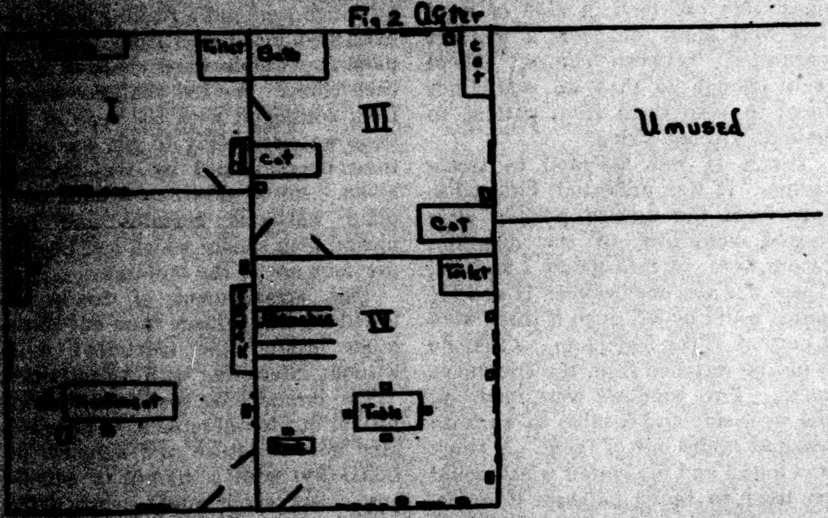
The staff agreed with these statements [illegible] slightly [illegible] and added that:

1. They were sure that it would [illegible] of the hospital to [illegible] of their [illegible] would be diverted [illegible]



I
III
II
IV


[illegible]




[illegible] show windows. Heavy [illegible] radiators.

[illegible] in the remodelled build- [illegible] covered with linoleum that [illegible] compared to the storeroom [illegible] floors had been [illegible] wing of the hospital not [illegible], and the walls were of [illegible]. Windows and doors [illegible] in the old building. [illegible] was found to [illegible] to use.

[illegible] as a workroom. [illegible] was fitted with a [illegible] so that it could be [illegible] for ventilation. [illegible] between I and II was [illegible] feet. The sink [illegible]. A work table, [illegible]

and so forth, completed the furnishings. An old wardrobe which had been used for former occupants was painted and some shelves were added for linen and supplies. The bathroom was converted into a small toilet, the remaining floor space being thrown into the room.

Room III was to be a rest room after treatment. The partition between rooms III and IV was moved south 4 feet, giving floor space 20 by 22 feet. There was only one window, and ventilation was a problem, but it was the best we could do. Three cots, three tables, and three rows of benches were installed and a door cut through into room I. There was a door between room III and room IV which could be used if necessary, but was usually kept locked to prevent intrusion from the waiting room. The bathroom was left, and its racks were used for [illegible]. The cots had plain, washable covers on the mattresses and washable cotton blankets for use next to the patients. Woolen

[illegible] (the Wassermann [illegible]) If the [illegible] treatment was [illegible] of arsphenamine, [illegible] intramuscularly, [illegible] of each were given [illegible] a week. Then fol- [illegible] one each week, and on [illegible] another blood test was [illegible] made it possible [illegible] patients once each week [illegible] work, which was [illegible] Visiting Nurse Association.

[illegible] Wassermanns were nega- [illegible] the first course, a sec- [illegible]. It was treated simply [illegible] the progress, if any, of [illegible]. If negative after the [illegible], the patient was dis- [illegible] told to return in a month [illegible] symptoms recurred. If [illegible] return, the Visiting [illegible] was asked to look [illegible] report.

Gradually the doctors began to use the clinic room for private, paying patients. Some tried giving treatments in their own offices or in homes, after the hospital service was discontinued, but found it unsatisfactory. These fees supplemented the returns of the clinic sufficiently to pay extra salaries and expenses. At the end of the year, the clinic was functioning four nights a week; the doctor and I each had an assistant; we were handling an average of forty patients a week, over half of whom were paying full clinic fees; and best of all, the staff and board were coöperating to send patients, for they were convinced that no harm had been done to the hospital by the clinic, that the community was being served, and that the clinic was at least self-supporting and might sometime show profit.

# Preparation of Sterile Solutions

## *Method Used at the Christian R. Holmes Hospital, Cincinnati, Ohio*

STANLEY DORSEY

[illegible] method of preparing and [illegible]

C. P. chemicals and filtered to a brilliant clearness, is filled into each 2-liter flask on the etched portion of which the pharmacist marks a code letter by which he can later distinguish the solution for labeling.

A single sheet of No. 40 powder paper is placed over the mouth of the flask and crimped down over the lip. The purpose of this paper is to prevent [illegible], later used, from falling into the solution. A double thickness of dressing gauze, cut into [illegible] squares, is secured over this paper and is also crimped down over the lip of the flask. The cap thus far made is then [illegible] with a [illegible]-

# [illegible] Relationships between the Hospital and the Private Duty Nurse[1]

E. I. ERICKSON

[illegible] private duty nurse occupies [illegible] place in the care of [illegible] patients. She is [illegible] member of the hospital [illegible] but she is called in when [illegible] of a patient is such that [illegible] individual care is needed. [illegible] are many patients who [illegible] such care even though [illegible] necessity. At times [illegible] a mere matter of pride, [illegible] be no question that it is [illegible] most nearly ideal care, [illegible] nurse can give all of her [illegible] to one patient instead of [illegible] among several, as is [illegible] on general duty.

[illegible] the private duty nurse is [illegible] the permanent hospital [illegible] is, nevertheless, a very [illegible] factor in the work. The [illegible] afford to make her a [illegible] organization because [illegible] fluctuations be- [illegible] and [illegible] de- [illegible] by general duty nurses [illegible] patient and, except [illegible] critically ill, con- [illegible] can avail themselves of [illegible] for those who can [illegible] expense. It is well [illegible]

[illegible]

Private duty requires a versatile individual who is able to adjust herself to varying conditions. She must, on short notice, become an integral part of a complex organization. If it happens to be in the hospital maintaining the school of nursing from which she graduated she will find it relatively easy to adjust herself because she will already be familiar with technic, procedures and regulations which prevail. However, there may not be sufficient demand for her services in her own hospital at all times. Hence, if she wishes to work it may be necessary to take home cases or care for patients in other hospitals. In the latter event she will usually find it somewhat difficult to adjust herself to an organization which in various respects may function differently from that with which she has been familiar. This is particularly true on the occasion of her first assignment to a foreign hospital.

Since the duration of cases is uncertain, varying from one day to weeks or months, there is a possibility of being called to serve in several hospitals in a comparatively short time. Naturally, a nurse finds it difficult to cope with such a condition. For the capable and conscientious nurse who gives a good account of herself this should not be of frequent occurrence and I think that the hospital and registry can to some extent control this situation, if the nurse will apprise them of the fact that she is getting more than her share of short cases.

The hospital management must realize the importance of its private duty group and give due consideration to the problems involved, in order

[illegible] she must look after [illegible] Her [illegible] and [illegible] to her high calling [illegible] to the sick, are as [illegible] they are somewhat [illegible] necessity of earning [illegible] the nature of her work [illegible] that she must satisfy [illegible] a time. Employ- [illegible] because there will [illegible] work and other [illegible] In the [illegible] her patient [illegible] build up a clientele, [illegible] of a more [illegible] for her services.

[illegible] however, [illegible] of the necessity [illegible] give adequate care [illegible] whether on [illegible]

acter as there are different patients or nurses, it is plain that there must be a definite control over the amount of leeway given. It is certain that, without restrictions on the part of the hospital management, costs would be vastly increased over their present level. There is no reason why the patient occupying private accommodations should not pay a profit to the hospital, nor why this margin should be reduced by unnecessary expense due to carelessness or unusual demands. I cannot help feeling that it is as much of a privilege for the private-room patient to have access to the facilities of a general hospital as it is for the patient paying less than cost or nothing. The well-to-do suffer from the same diseases as do the poor, and even the extremely rich would not deem it economy nor wisdom to build hospitals for their own particular and individual needs.

In saying these things I do not want to go on record as having indicted the private duty group as a whole, but merely to mention some of the tendencies of individual nurses after they graduate, and to point out the necessity for them to appreciate the responsibilities of the hospital.

It must be admitted that the hospital on its part does not have quite the same paternalistic interest in the graduate nurse that it had when she was a student, but it is still interested in her welfare. Pride is taken in the [illegible] of each individual nurse and [illegible] is given her in securing [illegible] or other positions [illegible] private duty is [illegible] the hospital makes every [illegible] its own graduates first [illegible] from other [illegible] its own [illegible] qualified for [illegible]

[illegible] upon the nurse. It [illegible] if such conversa- [illegible] on in the hearing of [illegible] patients. When she [illegible], it should be taken [illegible] supervisor and, if [illegible] results, she has [illegible] office.

[illegible] and charge nurses [illegible] coöperate by render- [illegible] promptly as needed. [illegible] in close contact [illegible] nurse and her patient, [illegible] and suggestions when, [illegible] they are called for.

[illegible] favors to either [illegible] will depend upon the [illegible] patients and nurses on [illegible] difficulties can be [illegible] connection, [illegible] when a decision [illegible] because, with so [illegible] with different likes [illegible], it is impossible for any [illegible] give 100 per cent satis- [illegible]

[illegible] has, or should have, [illegible] and it may be [illegible] of policy involv- [illegible] to it for approval. [illegible] with the [illegible] will usually [illegible] and agreement.

[illegible] which I represent [illegible] care of our private [illegible] from the ranks of [illegible] to a great [illegible]

ates from our own school. This is largely an individual matter and, when this is not true, there must be some underlying cause which may be the fault of the hospital and should be remedied.

I have tried to set forth frankly some of the requirements of both the hospital and the nurses which will ensure good relations.

In conclusion, a hospital, like a home, does not fulfill its purpose simply because people work or live there or because it has a suitable building with fine equipment or furnishings. There must be a spirit of helpfulness and respect for the rights of one another, with a desire on the part of each one to contribute something for the good of the whole. This spirit will make a real hospital as well as a home.

The private duty nurse is a splendid type of individual with high ideals and she is anxious to please her patient by giving conscientious service. If at the same time she is loyal to the hospital organization she happens to be working with, and if the hospital on its part coöperates in every reasonable way, there should be no real problem that cannot be solved. That there should be differences of opinion is only natural but with due respect for the authority of the hospital and an appreciation of the fact that rules and regulations are a necessary part of the best care of the sick, and that the private duty nurse needs the hospital as much as the hospital needs her, we should be able to carry out our mutual aim of service to the patients without undue difficulty.

# Hospital Relationships from the Private Duty Angle[1]

FRANCES M. HEINRICH, R.N.

WHEN I was asked to present a paper on this subject I did not realize what a peculiarly difficult task had been allotted me. Perhaps you wonder why I make this statement, for it may seem a simple matter to present this subject, but I feel sure you will all agree with me that there are many angles and that, in approaching each one, I must be fair to both sides, with a frank, unbiased, and open mind.

First of all, I feel that to have a perfect understanding and happy relationship between the hospital and the private duty nurse, each must be able to understand the problems of the other, and in order to gain contentment for the patient, who is after all the center, there must be perfect coöperation of those who have his welfare in hand.

In order to cover this subject briefly, I feel it best to divide it into two parts: the first that of the hospital, the second that of the nurse.

From the hospital angle I shall start with the office of the superintendent of nurses and divide this into component parts for closer consideration.

## *The Hospital Angle*

HAVING reached the office of the superintendent of nurses, let us note how the nurse reporting for duty is received, what instructions are given her as to rules and regulations of that particular hospital.

1. If she be a newcomer, she should be handed a printed list of rules.

2. Someone should be ready to direct the nurse to the patient, so that she does not lose valuable time or become embarrassed by wandering aimlessly about.

3. Adjustment of any difficulties which may be presented by the nurse should be through the office of the superintendent of nurses if proper adjustment is not made through the floor supervisor.

4. Adjustment of complaints of patients, such as lack of courtesy or attention by any hospital employee.

5. Investigation and adjustment of inability the nurse may have in obtaining necessary supplies from the service, linen rooms or diet kitchen, if no satisfaction can be had from the floor supervisor.

6. Proper assignment of cases, with fairness to the patient as well as to the nurse.

7. Investigation of reported refusal by nurses for certain types or [illegible] of patients.

8. Proper dressing-room facilities, with adequate locker space, keys for same, room to be well ventilated and lighted and not overcrowded.

9. Should a hospital feel privileged to register against certain nurses, these nurses should be given the benefit of a hearing before a representative committee made up of a member of the private duty section of the district association conducting the registry, a member of the hospital staff, a member of the alumnae of the hospital, and a member of the alumnae to which the nurse belongs.

10. The hospital should be privileged to deal with a nurse who is spreading malicious gossip or who is not living up to the ethics and standards of the profession.

11. [illegible]

12. [illegible] when a patient has called and is willing to retain a nurse, for the doctor to discharge that nurse? This happens fairly often. [illegible] could be done in a tactful way. Has anyone any suggestions?

[1]Read at Registry Round Table No. 1, Biennial Convention, Milwaukee, Wis., June 12, 1930.

12. [illegible] of the floor supervisor and the [illegible] should be courteous, fair, firm and [illegible]. As special nurses in most [illegible] give detailed written daily [illegible] patients, is it necessary that the floor supervisor make frequent or infrequent [illegible] patient's room? Would it [illegible] for that supervisor to take that [illegible] up more closely the work of the [illegible] nurse in regard to the care of the [illegible] patient and ward routine? It should, however, be the duty of the floor supervisor to enforce the following:

(a) Quiet in corridors, rooms, and at chart desk,
(b) Conservation of hospital supplies,
(c) Neatness in appearance of nurse,
(d) Tact in discussing conduct or management of staff with the student body.

13. Nurses' meals. A well balanced diet with pleasant surroundings and dining-room service is every nurse's privilege and right. The [illegible], for example, too often is [illegible] of consideration to needs and [illegible]. Also, nurses having to follow special diets should, upon recommendation of their physician, be accorded the privilege of being served such a diet through the diet kitchen.

This, I think, about covers the hospital angle; let me now proceed to the nurse's angle.

## *The Nurse's Angle*

1. How does she introduce herself; what is her appearance and general attitude?

2. How does she accept instructions given her?

3. If difficulties arise, how does she face them? Does she bluster or scold, or does she [illegible] try to reason them out before making [illegible] to take the matter to the office of the superintendent of nurses?

4. When patients complain of dissatisfaction, what does the nurse do? Is she loyal to the hospital and the physician in charge, yet [illegible] the patient and gaining a [illegible]?

5. [illegible] in securing necessary [illegible] with the [illegible] in her use of [illegible]? Is she not justified [illegible] for her patient [illegible] and [illegible] always fair in the matter of [illegible] or rejecting calls, or retaining the [illegible].

7. In the matter of dressing-room facilities, is she considerate of the rights of others, does she coöperate in trying to maintain order and neatness? If so, she is entitled to comfort, convenience and consideration. Here I would suggest that on each floor, preferably in the dressing-room, there be a cot, so that the special nurse might relax for a few moments during the long, twelve-hour day.

8. If the hospital fails to call a nurse for special request, is it not that nurse's privilege to ascertain why she has not been called?

9. Nurses cannot be too careful in listening to or spreading malicious criticism or gossip, and the method of avoiding this pitfall is to concern ourselves only with our own affairs. It is, of course, a great temptation to talk over our problems and also those of others, but it is very dangerous, and generally leads nowhere. One must have an open mind and be able to place herself in the position of others. However, I do feel that one must have the courage of conviction, and I do believe that conditions can be corrected or adjusted if properly approached. And how better than by taking them to our private duty section meetings? Above all else, we as a group should be most careful not to discuss hospital routine or management with the student body.

10. The nurse's attitude toward supervisors. If she expects courtesy, fairness, coöperation and consideration, she must herself observe these niceties. However, if she feels she does not get what she needs for her patient, or the coöperation she deserves, she is justified in taking her problem to the proper authority, the office of the superintendent of nurses.

## *Summary*

To summarize, I have tried to cover many points, but feel sure there are many I have overlooked. It seems to me that the crux of the situation lies in this: first, the broader our outlook on life, the better we can appreciate the problems of those about us; second, we must take into consideration the fact that we all tend to become specialists and therefore are apt to be narrow or biased in our views. The greater experience we have in nursing, and in the amenities of life, as well, the better results we can obtain and the happier we can make our relationships, not only with

our patients but with those with whom our work is so closely allied. In my opinion, there is too little stress laid upon the importance of the nurse's need for a broader experience after graduation, for specialization tends to absorption and makes one forget how to play and enjoy life as well as work.

Each branch of nursing is an education in itself; therefore the nurse who changes her line of work at different periods of her career, taking, for example, a few years of institutional work, public health, social service with postgraduate courses, additional schooling and private duty, must have a better understanding of the individual situation and be a more useful member of the profession. An interest in music, art, literature, domestic economy, dancing and other social recreations, should be included in a well-rounded experience. However, it would be difficult to take any active part in these activities with the present working schedule of the private duty nurse. For instance, for those doing twelve-hour duty, there is very little time left for outside interests after the long twelve-hour stretch, and the twenty-hour duty nurse is worse off, if anything. Nurses must get together on this. It is not asking too much to work for a ten-hour day.

I feel that any superintendent of nurses should have had some contact or direct experience in several of the other branches of nursing, especially a bit of private duty, for only then can she, and through her, her staff of workers, be able to appreciate the problems confronting the private duty nurses. I feel, too, that every private duty nurse, at some time during her career, should have had experience other than private duty nursing, thus making the relationship of the hospital with the private duty nurse clearer and happier.

## Long before the Official Registries

A DIRECTORY for Nurses in Philadelphia was formally opened on May 15, 1882. The acknowledged success of the work has been due to the following facts:

(1) The directory is conducted under the management of the College of Physicians, an eminent body of regulars, who undertake nothing that is in any way opposed to true medical science; (2) the great care manifested in obtaining nurses, each applicant being subjected to the most comprehensive questioning; (3) the devotion of the nurses to their work.

Taking up more closely the second of these causes, let us see how carefully the rights of the community are guarded against ignorant or unworthy applicants. In the first place, graduates of recognized training schools are registered on presenting their diplomas, without further reference. To all others blank forms are given requiring a statement of the name, age, address, qualifications, kind of nursing preferred, rates of charge, and both family and medical references. References to three physicians must be given, together with the names and addresses of three families in which the applicant has nursed during the past two years. Confidential blanks are then sent to each of the three physicians referred to, asking for information concerning the applicant's character and qualifications.

The confidential blanks to the families where the applicant has nursed are equally searching in their questions. If the replies from the references are satisfactory the nurse is registered after the payment of a fee of three dollars. The supervising care exercised by the management does not stop here, however; for, after every engagement, detailed inquiries are sent to both the physician and the family, in order to learn more and more of the nurse's qualifications.

The Directory reserves the right to drop any name from the register if grave faults or defects are proved against the person.

This registry had [illegible]

Trained nurses are in demand and many more are needed. The Directory is not only for those who want the highest priced nurses; the wants of all are provided for. Many of the nurses charged only from five to eight dollars a week. The rates are fixed by the nurses themselves. All that the Directory does in this regard is to register the charges and to see that nurses do not charge beyond the stipulated sum.—From the *British Medical Journal*, Sept. 1, 1882.

# Registry Relationships[1]

## *From the Angle of the Registry Executive*

MARY MARGARET MUCKLEY, R.N.

To MEET the community's need for nursing care, to create a central headquarters for nurses and nursing interests, to maintain a high standard for professional work and ethical conduct for its members; these are listed as reasons why nursing organizations operate and maintain an official registry. The putting of these objects into motion create the registry's problems. The problems of a registry are many and some may seem too small to mention, but in dealing with several hundred human personalities, each having tastes and desires a bit different from the other, a number of difficulties appear for adjustment.

Time does not permit a complete listing of problems, and so a few of the more troublesome ones have been selected because of their far-reaching effects.

The registrar has to deal with four groups of persons:

1. The nurses who make up the registry membership.
2. The hospitals to which the registry members go when private duty care is needed.
3. The physicians and surgeons who call private duty nurses to care for their patients.
4. The general public to whom care is given and who pays the bills.

To have the registry program run smoothly, each group must be pleased to a certain degree, and this must be done without upsetting the ideals of the nursing profession or the policy of the registry organization.

Nurses, of course, have the greatest interest in the registry. It gives them their professional backing. It is the one central point through which their professional aims and progress go on, and yet they do some funny things. They forget that sickness is no respecter of persons, times or places. They refuse to take certain cases, or to go to certain places to care for patients. This sometimes nullifies "that the registry was organized to give skilled nursing care to patients in its community." All patients cannot or will not go to the hospital and have special nursing care, too. So they often choose what seems to them the lesser evil—the care of a practical nurse in the home—and many registered nurses wonder why home work is falling off. It is impossible for any registrar to develop or keep up calls for nurses in homes if she has no one to take such cases.

Registry members seem to depend so much on "What's my number?", little realizing that personality, ability to adjust oneself, age, professional background and often nationality are listed first when a call is placed for a private duty nurse. We have for some time been trying to bring this home to our members but we are far from complete success. The professional background of the nurse gives the registry executive less concern than does personality. "She is a good nurse but—" or "She gave good nursing care to the patient but she did not fit in" are said so often about nurses. Since the vast majority of nurses in any community are doing private duty nursing, it is no small piece of work to equalize the calls and have every patient feel that his nurse fits in beyond criticism. Selecting a

[1] Read at Registry Round Table No. 1, Biennial Convention, Milwaukee, Wis., June [illegible]

nurse who will do best with the especial case for which she is called, is of course the ideal way, but this is not often the privilege of the registrar. When a certain nurse is asked for, she is sent, regardless of whether she is number one or fifty, and if a certified nurse is not asked for, the registrar is bound by rules to send the first nurse who is not registered against the type of case for which the nurse is being called. The members of our official registries meet the minimum requirements as to professional rating, and yet many are [illegible] in adjusting themselves and so [illegible] in personality, but they have the necessary credentials, they pay their dues, and so it becomes the registrar's task to see what can be done to make them succeed.

The registry membership has been and will always be just what the nursing schools graduate. The registrar must often wonder just why some nurses were permitted to finish their training, especially when there is difficulty in getting the superintendent of nurses to give frank statements of their work as students. Nursing schools graduate students whom they will not call back on cases. Many vital reasons are given, and yet it is expected that the registry executive will take the responsibility of sending them on cases in homes or other hospitals. Often these nurses do well in some other line of nursing, if the registry executive can interest them to prepare for and to enter some other nursing branch. Too often, however, they fall back on the registry again, and the complaint sounds once more: "Why did her school graduate her?" The nurse is going into the home or the hospital to care for the sick and she is the representative of the registry in every instance. Can we afford to continue taking on members who are not pleasing to family or patient? Should we carry these members, knowing that when we send them on cases, in twenty-four or forty-eight hours they will be back on call and the registry will be asked to send another nurse, "not her type." Are we doing justice to patients and nurses in general?

What the registrar should do for the graduate of years ago often causes no little concern. She is a woman well versed, of good personality, industrious, willing to take cases anywhere, but patients and physicians prefer the younger women. When calling for a nurse they will often state approximately what age they would like the nurse to be, and when specifications are not made, and the older nurse is sent, she may be embarrassed by being told she is "too old to take care of this patient"; yet she is not disabled, and she gives good nursing care from every angle, but because she has advanced beyond a certain age, she is termed "too old." Even though she has done private duty nursing during her entire career, this older nurse is often the one who has given time and service unlimited in the organizing of the nurses' association and in the advancement of the nursing profession and it does seem that some consideration is due her.

The registry members can be the best publicity agents. The way in which they execute their work, fit into situations, collect their fees, cooperate with the physician and the hospital, their attitude toward problems which arise in connection with their work, will all be [illegible] the advantage or disadvantage of the whole [illegible] [illegible] for all nurses [illegible] by what [illegible] [illegible] the only [illegible] [illegible].

In dealing with [illegible] the [illegible] [illegible] [illegible] registry is often the only link between the

private duty nurses and the hospitals, and it is given blame for much over which it has no control. If nurses do not wish to take certain hours or certain cases, hospital executives often feel that the registry should force them to do so. It is true that registering against hours and cases reduces the amount of work the nurses may have, but on the other hand, why force any one to do that which makes her unhappy? Sometimes nurses are called when so little information regarding the case is given that almost high pressure salesmanship must be used to secure a nurse. Nurses cannot be blamed for resenting this, for in very few instances is it impossible for the hospital to be able to give some idea as to the nature of the case. If the nurse can be given even a wee bit of such information, she will know what to expect and she will make a better approach to the patient. If hospitals do not call their nurses according to number, or if a nurse is called for the hours or cases she registers against, and the like, it is so easy to put the blame on the registry. A clearer understanding between the hospital, the nurse, and the registry does away with practically all such difficulties. Hospital executives and registry members alike have a very faint idea of how a registry is operated, and were both parties to take the time to visit the registry office, to observe how this work is done, a difficult problem could very soon be eliminated.

With the medical profession, the problems are different. Many members of this group know little or nothing about registry conduct and just as little about nursing. Many do not consider the nurse a co-worker, nor do they understand what the nursing profession stands for; some do not know the difference between a registered nurse and a practical nurse, and so the fun of straightening out troubles and misunderstandings goes on.

If the three groups already mentioned—nurses, hospitals and physicians—understand to some degree the aims and policies of the organization which maintains and operates the registry, the fourth group, the public, will quickly be a staunch supporter. For what the public wants is good, skilled nursing care, and it will ask for such service when it knows that it is available and where it can be secured.

The registry has for its membership private duty nurses and is, therefore, concerned first with the needs, life and aims of this group, which makes up about three-fourths of the membership of any local nurses' society. The private duty nursing group make contact with more persons in any given community than do nurses in any other branches of the work. Those outside the profession know nurses first through the private duty nurse. It would, therefore, seem not to be amiss to have a lay advisory committee to the registry, with whom and through whom much healthy and sound public education could be done. This committee, a picked one to begin with, and having on it both men and women to represent the hospital council, medical, and dental professions, persons in business and the educational field, could do a great deal of word-of-mouth publicity in selling registered nurses' services. Objections are often raised, when mentioning such a committee, because nurses feel that it would want to dictate all the policies of the organization. No doubt some members of a lay group would enjoy doing so, but that can be controlled. Lay people have helped markedly in the cause of public health, through the many national, state, and local societies, and I see no reason why they

should not be given a chance to help the cause of the private duty nurse through her registry.

Registries are gradually but surely taking a definite place in the community, and in doing so success can be reached only by having a sympathetic understanding from persons outside the profession, who are educated to understand, and, knowing the aims and desires of the nursing group, will lend their assistance. Registries have existed for some time but only recently has their importance been recognized. The registry office forms a logical headquarters for the association members and the demands made upon it are constantly growing. The executive in charge is an important person, as such, and if she fulfills her duties well, she will realize her responsibility in seeing that the nursing needs of the community are met. It may be that the program which a registry has been carrying on no longer suffices. The change in conditions may call for a change in registry work. It is a huge problem at times to swing this and to win over the committee in charge of the registry operations and the board of directors of the association. The registry cannot think only of hours and fees for the registered nurse, her life and aims; it must also consider what the community needs and do its best to meet this need. Practical nurses fill a certain need, and they are here to stay. Making it possible for a good grade of practical nurse to register at our official registries and controlling the fee she may charge and the types of cases she can handle, and supervising her work would be a big step toward meeting the community needs. Hourly nursing too may be a service the community would appreciate. I know many nurses believe that hourly nursing should be a part of visiting nursing, but I have not in mind the work of teaching and supervising, but rather the home where the patient needs, wants and can afford to pay for one or two hours of skilled nursing care per day, at a rate per hour which covers the entire cost. To such needs as these just mentioned the registrar must give thought and study. Requests for varied nursing services come to her, but it is not always easy to get the committee in charge to see the necessity for making provision to meet them.

The problem of the utilization and distribution of private duty nurses demands serious consideration. "We graduate too many nurses" is a cry heard so much now. In looking over the situation in smaller cities, one is prompted to say "coagulation, not over-production." To interest nurses in locating in smaller cities and surrounding themselves with a clientele either in private duty or in hourly nursing would be a means for patients to have better nursing care, and nurses engaged in nursing to have more work. I can feel someone thinking that that can't be done. But until a nurse gives this a trial she can scarcely say that it will fail. Repeated refusal to go out of the city on cases, has turned the attention of patient and physician toward the practical nurse. It is very difficult for a person to be in favor of skilled trained nurses when he has so little opportunity to make comparisons. We have a member in our association who located in a town of 4,000 population about forty miles from Minneapolis. She is doing private duty, receiving the same fees, working the same hours, that the nurses do in the city and she is not wanting for work. When the spirit moves her, between cases, she comes to the city and shops, sees plays, and goes to places she is interested in. She

says she is saving money and enjoying her work. But she is doing something much greater than that. She is making it possible for patients and doctors in that little town to know what good, reliable and intelligent nursing care is, and what it can mean to the patient and his family.

The registrar's problems are increased or decreased according to the association's program of public education in regard to private duty nursing. Because private duty nursing is older than some of the other nursing branches and because private duty nurses meet many families during the year, not enough attention is given to the fact that, in spite of this, the public does not know enough about the registry. Articles in periodicals which are read by local persons do not suffice; nurses, not having been trained as advertisers, can give little publicity help. Public education is two-thirds of any game, and must receive thought and attention if any amount of success is to be hoped for. Opportunities for public education must be grasped as they present themselves, and opportunities must be made to send out the message of the value of a trained nurse by mouth or print. This must be done with tact and diplomacy. We have stayed away from publicity so long that great care must be exercised in putting our value before the public. We cannot give publicity to the individual private duty nurse because her work is such intimate, personal service. Therefore, the organization of which she is a member must be used as the unit for publicity. The usual advertising card in magazines and the like, which many registries use, has little or no value; it does not seem to reach the right persons. Too much of such publicity is being done and it falls by the wayside because a nurses' registry advertisement looks like any other, and when some ten or twenty advertisements are crowded on a page, it merely resembles a patch in the printer's crazy quilt.

Since the care of the sick is the nurse's task, and sickness may visit any home, those who are prospective patients must be taken into our friendship and permitted to know us as we really are, and through knowing us, they will be workers in carrying on a program of public education.

By the time the problems that I have mentioned are solved, new ones will be sprouting. Each new development brings its difficulties. Changing conditions make new demands and this indicates life and growth. The nursing profession possesses both. Signs on the horizon foretell that in the future as in the past the nurses will meet the situations as they come, and do it satisfactorily. I am sure that at such gatherings as this, much helpful information can be gleaned, which when taken home and put to use will tend to lighten the registry's burdens.

# The Relationship of the Registry and the Private Duty Nurse[1]

LENA M. SCHMITT, R.N.

THERE seems to be a very urgent need of a better understanding of what the job of the registrar involves in her relationship to the registrant; and what the relations should be between the registrar and the private duty nurse enrolled on the registry. It is only by a study of the needs of the registrar, on the one hand, and the registrant on the other that we may learn the best interrelations to promote closer collaboration, and to find if possible practical methods for cooperation in order to meet the needs of patients and at the same time equalize the burdens and privileges of both the registrar and the nurse.

The registry is primarily a medium through which the public may be supplied with nursing service, and secondarily a medium through which the nurse may receive calls to render this service.

The obligations of the registry and the nurse are reciprocal. This reciprocal relationship holds as truly between the private duty nurse and the registry as in any other "give and take" relationship. Many nurses look upon the registry as a place of convenience, while the registry looks upon the nurse as a medium through which the business of the registry may be carried out most efficiently. In many cases neither the registry nor the nurse recognize their mutual responsibilities.

The obligation of the registry is to supply calls to the nurse in a fair, impartial manner. The obligation of the nurse is to be ready, after she registers, to receive and execute these calls promptly and efficiently.

To better understand why the private duty nurse fails to fulfill her obligations to the registry, let us consider her reasons for selecting the private duty field under the following headings—economic, professional, and social.

Nursing is an idealistic profession, but that does not necessarily render it immune from economic consideration. The advantage of a fairly high daily wage with board included may appeal to the young graduate. In her mind she figures she will have a greater remuneration than in another branch of nursing, where the daily compensation is less than in the private duty field. This shows lack of sound economic training, as income computations must be made on an actual earned, yearly, basis. The nurse often starts out with this idea of high wages in mind, gets caught in the mesh of private duty routine, and follows the line of least resistance, staying in the private duty field.

Our study of the report of the Grading Committee has shown us that:

> The amount of money the typical private duty nurse earns is pitifully small, and in addition the nurse works under the serious handicap of never knowing from day to day what her income will be. Private duty nurses live from hand to mouth. This system is hard.
>
> The incomes of private duty nurses are, however, definitely less than that for nurses in either the institutional or public health fields. While there are some high earnings, half the nurses in private duty earn less than $1,200 a year. Some earn only [illegible] or [illegible] a year and are living on savings or gifts from relatives.

Professionally, the nurse's reason may be that she enters the private

[1] Read at the Registry Round Table, Milwaukee, June 12, 1930.

duty field in order that she may have an opportunity to develop along one special line, *e. g.*, obstetrical, pediatric, or psychiatric nursing. She may wish to work with a group of specialists, or an individual specialist. It may be from a desire to render complete service to the patient, giving full satisfaction to the patient as well as to herself. Nurses working in hospitals or under a visiting nurse plan, do so under more or less pressure with the time element very definitely before them, while the private duty nurse who is interested primarily in giving complete service, is free from the burden of this pressure, and can develop her technical skill to an unlimited degree in caring for one patient. One registry says:

> We should like to feel that her motive is to take care of only one patient, but we have been forced to realize that it is more the lure of the free lance work method, where she is not bound to any institution. Those who understand the system best and have studied it closely think this probably is the rock upon which the private duty nurse will founder.

From the social standpoint she may enter private duty with the feeling that she is marking time until marriage will release her from the responsibility of self-maintenance. Therefore she takes neither herself nor her profession seriously. However, marriage does not always relieve the nurse of economic responsibilities.

The nurse in order to satisfy these professional, economic, and social demands allies herself with a registry. What may the nurse expect from the registry? The relationship of the registry to the private duty nurse must be a coöperative one in order to completely fulfill the purpose of their foundation.

If the registry states it is established to give nursing service to the community, coöperative plans should be mentioned. It is not coöperative unless the private duty nurse will keep in close touch with the registry. If there is any question in her mind as to whether she has been given fair treatment, for instance, she should understand the system of placing calls. There should be frequent meetings of registry and private duty nurse, as no coöperative enterprise can exist without frequent meetings for consultation and advice from both parties concerned. As to the method of assignment, it has become a rather fixed system in the official registries to list nurses as they register. This is not coöperative, because a nurse is not always sent on suitable cases, thus adversely affecting both nurse and community.

Registries have found it necessary to make some night duty compulsory. In the registry where the speaker registers, the first agreement the nurse must accept is that nurses accept the use of the registry with the understanding that they take day or night, hospital, or outside calls.

*Night Duty.*—It has been found necessary to make this ruling in order to fill night calls. Looking at it from the standpoint of the private duty nurse, who lives in the city where quiet sleeping quarters are at a premium, night duty becomes a very great hardship. If she does not get enough rest to compensate her for twelve hours' duty at night, it is evidently an abnormal arrangement. The constant readjustment between day and night duty is very trying, and it ultimately becomes a question of health. Hospitals often fail to provide relief for night nurses. The question here arises, Has the registry any responsibility in bringing pressure to bear to create more acceptable conditions for the private duty nurse? If night duty is to be compulsory, the

conditions of night duty must be improved.

*Out-of-Town Calls.*—The nurse is reluctant to go out of town on a case because this usually means 20-hour duty, which is in fact 24-hour duty if the patient is very ill. Usually the private duty nurse likes bedside nursing, but does not enjoy going on cases where she feels she is wasting time. Invariably, the nurse likes taking care of really sick patients, but does resent being compelled to spend hours and hours, listening until bored to death to tales of illness or family troubles, with persons with disagreeable personalities or worse, or with the pampered wealthy people who can buy everything but health.

In the case of the very sick patient she gets very little or no rest at all for an indefinite length of time. In the other case she feels it wasted time, which she cannot afford to give.

Home cases call for different technics from the hospital technic. The nurse must improvise and this is sometimes difficult for one who is not trained in home technic.

*Staying in for Calls.*—The registry does not require the registrant to have her name always on call, but it requires her to be ready for duty when she does register.

The Detroit District requires that the registrant who is on call must not be out of reach of the Registry for more than an hour at a time, without first notifying the registrar of the fact.

During long periods of unemployment when the nurse feels she must keep her name on call so not to lose her place, it becomes a very great strain on the nerves to sit at home ever listening for the telephone to ring. She is afraid to leave the house for fear of missing a call. This does not leave the private duty nurse very much time for relaxation and freedom from worry, or time to devote to interests outside her profession.

At these times the economic element enters in also. Her expenses are going on, she must live, sometimes even the price of telephone calls is an important item to her.

This whole condition seems to reflect upon one of the three great handicaps of the private duty nurse, as found by the Grading Committee, namely:

(1) The overproduction of nurses. This results in unemployment problems which are especially acute in the private duty field, since the field must absorb all workers who cannot secure either public health or institutional positions.

Has the registry any responsibility in trying to correct these conditions? It is important that people who come together to discuss this question, arrive at some conclusion as to whether or not the registry has responsibility in bringing about corrections to make it more of a coöperative plan.

Though we hear plans discussed to supplant the private duty nurse, it has not been proved that we can get along without her. So we must make conditions suitable for her to continue.

(2) The second handicap is that "Private duty is a free lance occupation open to all comers. Good nurses suffer from the competition of women far below their level in breeding and intelligence, professional ethics, and nursing knowledge and skill."

(3) The third is "The free lance worker in nursing, as in other professions, inevitably pays for her cherished independence of action through lowered income, irregular employment, and extreme professional loneliness."

However, we do know that there are extenuating circumstances to exonerate the private duty nurse when many criticisms are made of her.

In order to develop closer coöperation and mutual respect between the registry and the nurse, the registrant should avail herself of every opportunity of obtaining first-hand information concerning demands of the community for nursing service and the means whereby these demands are satisfied. No doubt one day spent at Registry Headquarters would be very revealing. With this background, the registrant would probably be in more sympathetic touch with the problems of the registrar. She would feel herself a part of the whole organization and not just an individual whose varied likes and dislikes must be satisfied at any cost. She would have probably a more tolerant attitude toward the assignment of cases.

This close contact would probably give the registrar a keener insight into the personality and potentialities of the registrant. It would probably awaken in the registrar a more tolerant sympathetic attitude toward the problems of the registrant and would quicken in her a desire to be of greater service and help in placing the registrant in situations which she is best suited to meet.

The following recommendations are offered as possible aids in the solution of some phases of our problems:

1. Some plan of grading private duty nurses and then assignment of duty according to merit.

2. Opportunity for growth, afforded by compulsory attendance at at least 75 per cent of Section meetings for two years after joining the registry.

3. Constructive leadership which would be developed as the nurse grows in group consciousness from attending the Section meetings.

4. Some plan by which the registrant and the registry meet at stated intervals to discuss their mutual problems.

In closing, may I say to the private duty nurse—

> But how can she expect that others should
> Build for her, sow for her, and at her call
> Love her, who for herself will take no heed at
> all?

# Publicity Campaign of the Shreveport, La., Registry Board

GENEVA A. PETERS, R.N.

DURING the World War and the influenza epidemic following it, there was a great shortage of nurses in this section of the country. It was especially difficult to find nurses who would go on duty in homes, on night duty, or into the rural districts. If we were able to fill these calls at all, it was with the type of nurse who could not get anything else to do and who took these calls as a last resort. This type of nurse may be readily recognized as the "misfit." The doctors for whom she nursed were dissatisfied, as were the people into whose homes she went, and a perfectly natural result of such a situation was that the doctors used practical nurses and, finding their services more satisfactory than those of graduate nurses, soon preferred them and grew to depend on them almost entirely.

As time went on, and the country settled down to normal conditions following the war and nurses became more plentiful, we began to find great numbers of nurses off duty, some of them for weeks at a time. We were not able to place them all in the hos-

pitals and we had very few or no calls from the doctors in the small towns in our district. One nurse, returning from a case in the country, brought us the news that the country doctors were using the practical nurse in preference to the registered nurse, saying that they found her more dependable and more satisfactory generally than the nurse who had been sent through our registry. Naturally, we felt this blow keenly and, after discussing it very thoroughly, we decided to try to make a "come-back" to the country doctor.

At a district meeting an appeal was made to the private duty nurses, who pledged their coöperation in filling these calls. This was in 1929, just a short time before the meeting of the Tri-State Medical Society in Texarkana. Cava Wilson, Secretary-Treasurer of our Registry Board, conceived the idea of going before this group of doctors and asking their coöperation in using our registry and nurses. Permission to send a representative to this meeting was obtained and Miss Wilson went, with the purpose of putting before that group of physicians the desire of the Shreveport District Nurses' Registry to supply them with efficient service in filling calls from both rural and urban areas.

A table was placed in the meeting hall on which was placed a placard about two and one half by two and one half feet with the legend:

The Shreveport District Nurses' Directory
Service Day and Night
Phone 3-4876

Cards were distributed with our fee schedules and general information concerning the directory. Several copies of the *American Journal of Nursing* were also displayed on the table. Constructive criticism was invited.

This was our first attempt at any form of publicity and our uniformed representative was most cordially received between discussions, when contacts were made. She was also invited to all dinners and social functions.

The warm welcome, the spirit of fellowship, and the promise of fullest coöperation from the doctors was most gratifying and so encouraged us that we sent a representative to the meeting held this year in Marshall, Texas.

We appeared also before the State Medical Society meeting, held in Shreveport this year. Jane Ingersoll, who represented the Association at this meeting, had prepared a map of Louisiana divided into districts. Each parish of the district was in a different color and each accredited school of nursing was reproduced in miniature and placed at its proper location on the map. Thus, at a glance, the districts, the parishes in the districts, and the nursing centers for the districts were seen.

Results: A happier relationship between our registry and the members of the medical society has been established, and a much better coöperation between these two bodies is enjoyed. The rural districts are being supplied with a better type of nurse, and employment is given to many nurses who otherwise would be off duty. Our Registry Board feels that it has been very richly rewarded for its efforts.

# Sympathy

[illegible] death of S. Lillian Clayton [illegible] to the American Nurses' [illegible] over one hundred [illegible] and cablegrams of [illegible] from all over the [illegible]

[illegible] reflected the high es[illegible] Miss Clayton was held [illegible] in the nursing [illegible] in the medical and [illegible] fields as well. Written [illegible] languages, in varying [illegible], the messages [illegible] deep regret and pro[illegible] of her death felt by [illegible] the nurse leader, [illegible] professionally. They [illegible] that Miss Clayton [illegible] the best known and most [illegible] in the nursing field in [illegible] as in other countries.

[illegible] state nurses' associations and [illegible] district nurses' associations, [illegible] of the nursing [illegible] headed by Miss Clayton, [illegible] the profession's great loss. [illegible] association wrote:

> [illegible] feel that they have lost a warm [illegible] friend. Miss Clayton was [illegible]

[illegible] State public health [illegible] the heads of the [illegible] Clayton, paid tribute [illegible] personality. [illegible] in [illegible] nursing and medical [illegible] of [illegible] ated and respected. Letters came also from allied nursing organizations and from hospitals whose contact with Miss Clayton had filled them with a great admiration for her sterling character.

From abroad came fourteen communications from presidents of national nursing associations, all affiliated with the International Council of Nurses, who felt that the loss to the nursing profession could not be estimated. From Asia, Africa, and South America, came seven communications which stressed, as does the following letter, their appreciation of Miss Clayton's wide range of interest, which included nursing problems all over the world:

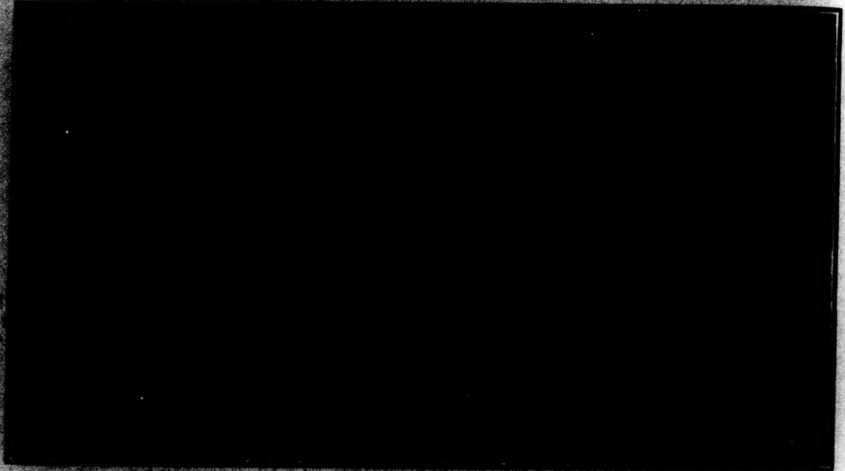
> When it has been necessary to recruit staff members from America, we have often consulted Miss Clayton and, heavy as her responsibilities were, she was always willing to take the time to consider our problems and give us her kindly but penetrating views on possible candidates.

Many letters spoke of Miss Clayton's graciousness as a hostess. A Belgian nurse leader wrote, "I will personally remember her charming hospitality and all the kindness she showed me last year when I was in your country." From another source came the statement, "She was always most cordial and kind in giving visiting members of our nursing staff and faculty opportunities to see significant work in her hospital."

The general feeling, summed up, is reflected in the words of a South African nurse, who said:

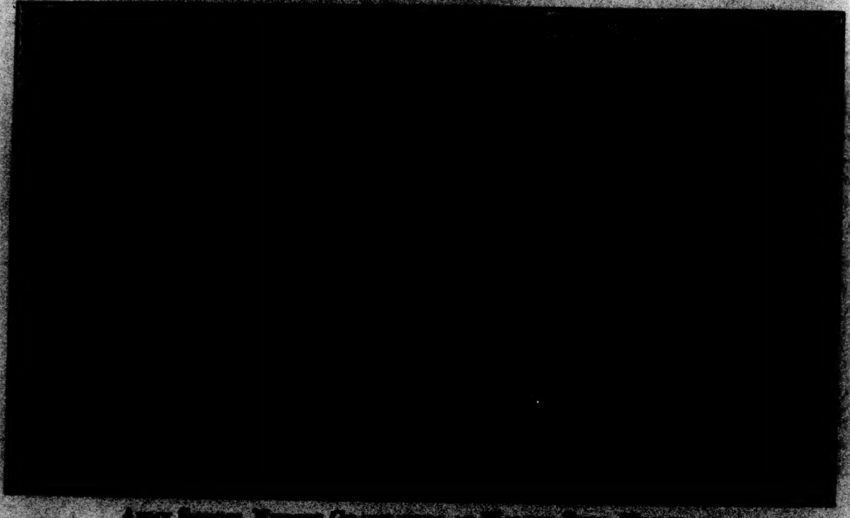
> We [illegible] in her passing America and the nursing world have lost one of their great leaders, but we know that the inspiration of her teaching and example will continue to [illegible] the profession she so [illegible] loved and served.

# Outdoor Commencements

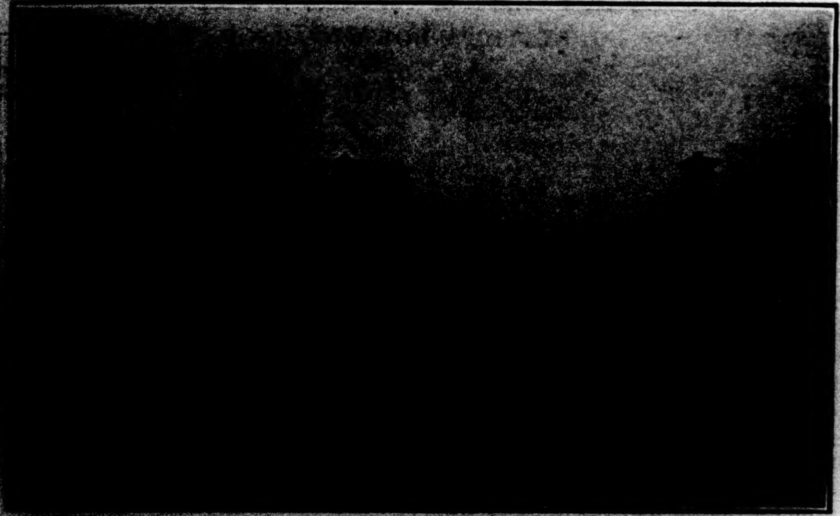


The Phipps Garden as a Commencement Setting

It requires a certain amount of courage to plan for outdoor commencement exercises, but those who have done it report that only occasionally has the weather been unkind. Infinitely better, they think, to "take a chance" than to have an overcrowded auditorium or, ultimate tragedy for the class, no exercises at all. The charming pictures of the Johns Hopkins Hospital class of 1930 are typical of the exercises hallowed by



Army School Nurses Graduating at Walter Reed Hospital



COMMENCEMENT AT JOHNS HOPKINS HOSPITAL SCHOOL OF NURSING, 1930
Dr. Winford Smith, Superintendent of the Hospital, and Miss Lawler, Superintendent of Nurses and Principal of the School of Nursing, leading the procession

years of tradition at that interesting place. By using amplifiers, class and guests, seated on the galleries around the four sides of the charming little "Phipps Garden," are enabled to hear perfectly.

Many years since, at the Newton Hospital, Miss Riddle established the custom, continued since her retirement, of erecting a marquee on the spacious lawn. Here successive classes have been, and still are, graduated with the benison of that gracious New England saint.

"Commencement in the garden" is crystallizing into tradition at the School of Nursing, the Presbyterian Hospital, New York City. The lovely green campus gives ample space for graduates and their friends, while at the juncture of two broad staircases curving up to the hospital is a platform for the speakers.

Smaller schools have adapted themselves to circumstances in various ways. At the Jewish Hospital, Cincinnati, although the exercises are held indoors in the evening, the reception for the class is held on the gayly lighted lawn.

Another Middle Western school uses a sunken garden as a setting for the "day of days." So, too, does the Army School of Nursing at Washington, D. C., as the picture so charmingly shows.

Indeed, no two nursing school commencements are quite alike. The setting may vary all the way from formal academic surroundings, the dignity of churches, or a school's own auditorium, to a garden. The completion of a nurse's training is a great event for her. Happy is she whose commencement is gracious, dignified, and full of promise.

# Disability Bill for Army and Navy Nurses

J. BEATRICE BOWMAN, R.N.

THE nurses of the country will, without doubt, be interested in learning that nurses of the Army and Navy are now entitled to retirement if disabled in line of duty.

The struggle to procure this act has an interesting history.

One who has not had the privilege, or, to put it more accurately, the anxiety of helping to engineer a bill through the Congress of the United States cannot possibly imagine the efforts and struggles made by those particularly interested. The "good men in Congress" are individually and collectively at work on "the people's business," so when a bill such as ours is proposed it must, indeed, be a worthy cause. In this manner came to life a Disability Bill for Army and Navy nurses. It had many "rewordings." I will give the data, but explaining why would take too long and probably would not be of interest.

The Honorable John J. McSwain, representative from South Carolina, first introduced a disability bill on December 7, 1928, and, to change its wording, re-introduced it on May 28, 1929, and again on May 20, 1930. The bill was referred to the Committee on Military Affairs. That we had interested friends all about us will be recognized by the fact that the Honorable Roy O. Woodruff, representative from Michigan, introduced a disability bill for members of the Navy Nurse Corps on June 3, 1929, and, with the advice of the Bureau of Navigation, re-introduced it on February 26, 1930, in order to give greater benefits. The bill was sent to the Naval Affairs Committee and was passed unanimously on March 13, 1930. It was then placed on the Consent Calendar and on May 19, 1930, was passed without objection by the House of Representatives, but with an amendment made by Mr. McSwain including the Army Nurse Corps. This gave us all great joy. The Senate passed upon it unanimously on June 11, 1930, and on June 20, 1930, President Hoover placed his seal of approval by signing the Act of Congress a little before the noon hour. This Act of Congress does not mean so much in money, that is, in comparison to the hundreds of thousands and millions that are appropriated, but it does mean a very great deal to the members of the two Corps who are now or who may be disabled. The Services have generously carried on the disabled members for years. They can now retire, be free to go forth in pursuit of happiness and health, with the knowledge that Uncle Sam appreciates the service already rendered and proves it by caring for them the rest of their lives.

The contents of the Bill is as follows:

[illegible]

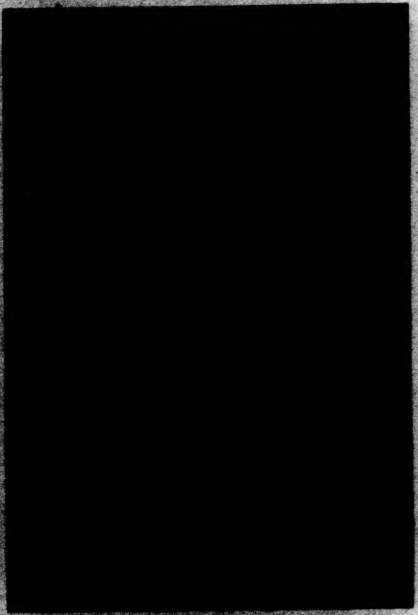
# Chemical Hysterectomy

ELEANOR HELM, R.N.

THE scientific world moves so rapidly that it is difficult indeed for workers in the various fields to meet the changing demands. Especially is this true in the fields of medicine and nursing. These professions have always felt their interdependence, but at no previous time has so much been expected of the nurse in scientific understanding and skillful procedure. The nurse today not only must keep up with changing technic in her own field but must also be alert to opportunities to assist the physician and surgeon in his. Of the many new surgical procedures with which I, as a nurse, have been privileged to assist, a chemical hysterectomy is an outstanding one.

A hysterectomy is the removal of the uterus either by laparotomy or through the vagina. Within the last few years doctors in the field of surgery have successfully performed this procedure chemically instead of mechanically. Zinc chloride, the chemical employed, is an escharotic, and it is used in saturated solution. The entire uterus is not removed, as in former surgical procedures. The chemical causes a sloughing of the endometrium and part of the muscle wall, in the form of a cast.

Indications for such a procedure are many. It is used essentially to destroy an infected endometrium or cervix such as occurs in chronic infections of the uterus that resist milder therapeutic measures. It is also used to produce sterility in cases of pernicious anemia, tuberculosis, epilepsy, insanity, and heart disease. It has been proved that the cervix is the focus of infection in many cases of arthritis and secondary eye infections, and frequently, because it is the seat



CAST REMOVED FIFTEEN DAYS AFTER OPERATION

V. S. Counseller, in *Surgical Clinics of North America*, February, 1930. (Courtesy W. B. Saunders Company)

of a chronic streptococcic infection, it is associated with menorrhagia, metrorrhagia and leukorrhea. These conditions are most common among patients over forty years of age; the patients occasionally are obese and have chronic heart or kidney disease. In these conditions radical surgical procedures may be contraindicated because of complicating conditions which may arise postoperatively. The chemical hysterectomy has proved a safe procedure on the part of both the surgeon and the patient and still accomplishes the same result as a total abdominal hysterectomy.

The patient is prepared as for any

vaginal operation. In the operating room the first step in the procedure is to test the uterus as to size. This is done by firmly packing it with sterile gauze, which is then removed and the same amount saturated with the zinc chloride solution. The saturated gauze is firmly packed into the uterus. The cervix is held shut by two towel clips to prevent leaking of the zinc chloride solution. The vagina is then packed with a sterile soda sponge. Soda is a neutralizing agent and in this case it is used to prevent erosion of the vaginal wall due to any of the zinc chloride's contact with it. The zinc chloride is allowed to remain in the uterus from twenty-four to thirty-eight hours, generally thirty-five hours.

The nurse has during this time put into practice general nursing care, but at the end of the specified time she begins a special series of important but simple tasks. It is her responsibility to notify the surgeon in charge of the case when the pack is to be removed. Upon his arrival she should have ready a sterile tray containing the following articles:

1. Sterile douche can with either a hard rubber douche nozzle or a metal irrigating tip.
2. Sterile saturated soda solution, 110 degrees F.
3. Bivalve speculum.
4. Lubricant.
5. Rubber gloves.
6. Sterile sponges.

Other articles necessary are: a sheet for draping the patient, small rubber sheet, towel, douche pan, blanket and a convenient light.

The patient is placed in a dorsal recumbent position on her bed and properly draped as for any other vaginal procedure. A blanket is placed over her chest. The small rubber sheet and towel protect the bed under the douche pan. The light is placed or held in such a manner as to shine directly on the field of work.

The doctor inserts the speculum which has been well lubricated and under direct vision begins to remove the soda sponge from the vagina. While this is being done the nurse should have ready the soda solution in the douche can, and when the soda pack and clamps have been removed, the soda solution is allowed to run slowly into the vagina. This is continued while the doctor is removing the zinc chloride pack. After its removal another long, warm sterile douche should be given and repeated every four hours for a period of twenty-four hours, or longer if the physician so orders.

The convalescing period, following a chemical hysterectomy, is in most cases uneventful. The course is usually afebrile, because of the rapid action of the chemical, thus preventing any absorption into the general circulation. From ten days to two weeks after the pack has been removed, the cast, consisting of the endometrium and part of the muscle wall, separates and is discharged into the vagina, leaving only a thin layer of uterine muscle which soon contracts to about the size of an infantile uterus. It may be necessary to grasp the cast with tenaculum forceps and rotate it in order to completely separate and remove it. Usually it is expelled spontaneously.

During the hospitalization period the patient receives general nursing care. Upon her return from the surgery she may have fluids as tolerated. The second day she may have a soft diet and on the third day a general diet. If a retention urethral catheter has not been inserted during surgery, catheterization may be necessary. Following the removal of the pack the patient should have no trouble in voiding. Enemata may

be given on the second or third day postoperatively, if necessary. As a laxative, one-half ounce each of mineral oil and milk of magnesia is usually prescribed three times daily.

The third day the patient may sit up in bed, but she should remain in bed until a day or so after the cast has been removed. Postoperative hemorrhage rarely occurs, but should it occur at this time a light vaginal pack is sufficient to control it.

The procedure may be a simple one when compared with the usual hysterectomy, but very often, particularly because it is new, it causes the patient a great deal of worry. It is the nurse's duty not only to give the patient efficient nursing care but also to demonstrate that under her starched professionalism there beats a sympathetic heart and an earnest desire to help bring about a successful result.

# The State in Relation to the British Nurse

HESTER VINEY, S.R.N.

As far back as the last quarter of the nineteenth century, a movement was made towards the state registration of nurses in England, but it was not until 1919, the year following the great war, that an act was placed upon the statute book giving to the nurse her legally recognized professional status.

This Act, which applied to England and Wales, is known as the "Nurses' Registration Act, 1919," and by it the formal machinery for regulating the training, conducting the state examinations and for registration was set up.

To carry out the terms of the Act, a General Nursing Council was established, consisting of twenty-five members, appointed as follows:

Two members appointed by the Privy Council, and of these members it is stated in the Act that they shall not be registered medical practitioners nor nurses nor persons concerned with the direction of or the provision of the services of nurses;

Two members appointed by the Board of Education;

Five members appointed by the Ministry of Health;

Sixteen nurses elected by the nurses whose names are on the state register, and these elections take place every five years.

The Chairman and Vice Chairman are elected annually by the Council and at the present time both offices are held by state registered nurses. The Registrar and Assistant Registrar and some of the other officials are also state registered nurses. The government department under which the Act is administered is the Ministry of Health.

The first duty of the General Nursing Council is to maintain a register of those nurses who satisfy the conditions laid down in the Act and in the rules framed under the Act. Up to 1925, registration was open to nurses without state examination, on adequate proof of training and experience. Many hundreds of nurses availed themselves of the terms permitting registration under these conditions. Since the period of grace expired, in 1925, the register has only been open to nurses under the following conditions:

1. The nurse must be twenty-one years old.
2. She must show a certificate or give satisfactory proof of her training in an institution or training school approved by the General Nursing Council.

She must have passed the examinations conducted by the General Nursing Council qualifying her to place her name upon the appropriate part of the state register.

The approval of institutions as

training schools for nurses is the responsibility of the General Nursing Council, which is charged under the Act with the duty of keeping a list of such institutions.

The schools are divided into those which are complete in themselves, offering all the necessary training and experience, and those which are affiliated or associated with other training schools which supplement their training facilities.

The following parts of the state register are maintained:

1. General part of the register for nurses trained in approved general hospital training schools.

2. Supplementary part of the register for male nurses.

Supplementary part of the register for mental nurses.

Supplementary part of the register for mental defectives' nurses.

Supplementary part of the register for sick children's nurses.

Supplementary part of the register for fever nurses.

The examinations for state registration are conducted three times a year in all parts of the country, and in the work approximately 300 doctors and 460 nurses are taking part.

The nurses enter for the state examination twice during their period of training: for the preliminary examination after not less than one year's training and for the final examination after the completion of not less than three years' training; in the case of fever nurses, not less than two years' training.

For the final examination, the nurse has to show evidence of:

1. Being twenty-one years of age;

2. Having passed the preliminary examination;

3. Having had adequate training and experience according to the rules governing the particular part of the State Register on which she desires to place her name.

The inclusive fees payable by the candidate for the examinations and registration are:

Preliminary examination, £3: 3: 0.

Final examination, £3: 3: 0.

The General Nursing Council has power under the Act to remove from the register the names of nurses of whose conduct they receive unsatisfactory evidence, whilst the nurse has the power of application for the restoration of her name upon the register, and for both actions a specific procedure is laid down. The state register is revised each year and the nurses pay a small retaining fee of two shillings and sixpence in order to keep their names on the register.

The General Nursing Councils for Scotland and Ireland were established simultaneously with the 1919 Act for England and Wales, but by separate acts for each country. Reciprocity was established with the three parts of the United Kingdom and has been continued with the Irish Free State.

The Empire, with its scattered population, naturally brought the question of reciprocity early before the General Nursing Council, and the following list is of interest in demonstrating the progress of a movement towards Empire reciprocity.

Reciprocity has been established with the following dominions and colonies:

| | | Arranged | | |
|---|---|---|---|---|
| New Zealand | Ratification | 6 | Oct., | 1922 |
| South Australia | " | 8 | Feb., | 1927 |
| Queensland | " | 30 | March, | 1927 |
| Western Australia | " | 6 | June, | 1927 |
| Burma | " | 19 | March, | 1928 |
| Natal | " | 8 | May, | 1928 |
| Victoria | " | 25 | May, | 1928 |
| Transvaal | " | 19 | June, | 1928 |
| Orange Free State | " | 4 | Dec., | 1928 |
| New South Wales | " | 8 | April, | 1929 |
| Tasmania | " | 27 | Sept., | 1929 |
| Cape Province | " | 27 | Sept., | 1929 |

The General Nursing Council for England and Wales appeals directly to

receive the ratification terms for reciprocity with the South African Medical Council for the Union of South Africa which includes Cape Town, Natal and Transvaal, and the Act of 1928 was extended to the Mandated Territories of Southwest Africa on January 4, 1929.

The Act for Scotland is the "Nurses Registration (Scotland) Act, 1919."

The General Nursing Council for Scotland works under the Scottish Board of Health. The Council consists of fifteen members with the following constitution:

One member appointed by the Privy Council who is to be a person who is not a nurse nor a registered medical practitioner nor concerned with the provision of or with the direction of the services of nurses;

One member appointed by the Scottish Board of Education;

One member appointed by the Board of Health for Scotland;

Nine members who are State Registered nurses elected by those nurses whose names are on the Register.

The registration authority for Northern Ireland is entirely separate from that of the Irish Free State since the separation in 1922.

The General Nursing Council for Ireland was originally established under an Act of 1919. This was followed, after the separation of Northern Ireland from the Irish Free State, by a further act—the Joint Nursing and Midwives Act (Northern Ireland), 1922—under which the work of registration is now carried on. This new Act established a Joint Council in Northern Ireland for the purposes of the Midwives (Ireland) 1918 Act and the Nurses' Registration (Ireland) Act of 1919 and for all purposes connected therewith.

The Joint Council established by the Act consists of ten members:

Four persons appointed by the Minister of Home Affairs, who are as follows:

One medical officer of health;

One member appointed to represent the Councils and the Borough Councils in Northern Ireland in connection with the midwives;

Two registered medical practitioners representing the registered medical practitioners of Northern Ireland; and in addition six members elected by the registered nurses and midwives respectively of which four are registered nurses and two are qualified midwives.

The Joint Council is charged with the duty of maintaining the register of nurses in Northern Ireland, of conducting the examinations qualifying candidates to place their names upon the general or supplementary parts of the State register.

This Joint Council has also the duty of approving the training courses for and conducting the examinations of candidates who wish to qualify as midwives, and of maintaining the roll of midwives in Northern Ireland.

The influence of this legislation controlling the qualifications of nurses has been far-reaching. On the educational side the hospitals all over the country have made great efforts to qualify themselves as approved training schools. These efforts included the appointment of sister tutors, the reorganization of the training school, and many other alterations and improvements.

The hours of work for the nurses have been decreased and their standard of general and professional education considerably raised, and a large part of the more fatiguing domestic duties has been eliminated from their work.

The nurses have borne their full share of responsibility in regard to the examinations. For the preliminary examination, the entire examination is conducted by nurses except for papers on anatomy and physiology, which are set by doctors and marked by them. The oral and practical examinations are conducted by nurses.

For the final examinations, all nursing papers are set by nurses, the papers on medicine and surgery are set by physicians and surgeons, whilst the oral and practical examinations are conducted in each centre by one physician and one surgeon and two nurses. All examiners are paid definite fees and travelling and subsistence allowances according to a definite scale.

For the nurse, although registration is not compulsory and she can practice without it, yet the advantage of registration becomes more apparent each year. Many appointments are only open to state registered nurses, and in others preference is given to them. The general public are slowly beginning to understand the protection offered to themselves by the Act and a legal penalty is attached for unlawful assumption of the title of State Registered Nurse and for falsification of the Register.

A standardised uniform for the registered nurses has been approved and protected, the rule being that only the state registered nurses can wear it. A permit must be obtained from the General Nursing Council before the uniform can be supplied by the makers.

The status of the nurse in Great Britain has been greatly strengthened since 1919 by her advanced standard of professional qualification. The profession which, even within the British Empire alone, offers wide opportunity of service to nurses, is attracting into it year by year keen and well educated probationers whose training and experience will enable them worthily to carry out the increasing duties laid upon the shoulders of trained nurses.

## Let There Be Sight

THE annual report of the National Society for the Prevention of Blindness bears the arresting title "Let There Be Sight." It is an unusually interesting report, from the picture of the adorable baby on the cover straight through its well illustrated pages.

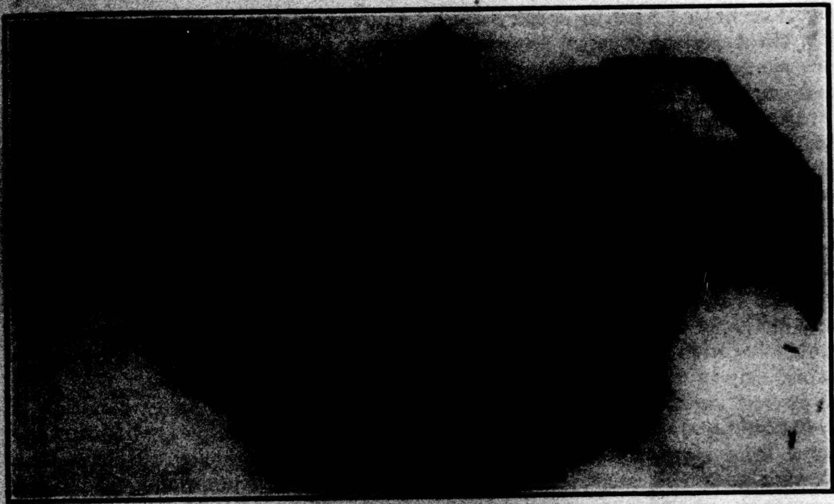
"We are especially concerned with the problems of that enormous number of children and adults, otherwise perfectly normal, who are constantly handicapped in their work or study and in their enjoyment of life because of defective vision," says the report. "With care, early in the life of a child, weak vision often may be strengthened or, at least, frequently kept from diminishing and perhaps being lost entirely. Science is teaching us that most of the causes of blindness are preventable.

"There are now 380 'sight-saving classes' for the education of children with seriously defective vision in the 95 cities of 21 states. Through the use of large-type books, movable desks, ideal lighting, and special teaching methods, children with little vision are not only given the same sort of education that children with full vision receive, but they are taught how to conserve their remaining sight. The Society estimates that approximately 5,000 such classes are needed in the United States. To train teachers for this work, special courses will be given in the coming summer months at Columbia University, the University of Chicago, the University of Cincinnati, and the State Teachers' College in Buffalo, N. Y.

"Trachoma, the disease of the eyelids which leads to blindness, continues to baffle the best minds of ophthalmology. Renewed impetus to research into the mysteries surrounding it was given through a five-year program of investigation started recently by the Medical School of Washington University, St. Louis, and financed by the Commonwealth Fund. In addition to cooperation with the federal trachoma clinic at Rolla, Mo., during 1929, the National Society for the Prevention of Blindness assisted several other agencies in a study of the incidence of trachoma among the Chippewa Indians of Minnesota."

# An Ambulance Emergency Kit

MARGARET PETERS, R.N.



THE kit was devised and constructed by W. J. Rogers, our chief engineer, and consists of a metal case 16 inches long, 8 inches wide, and 9 inches high. It is opened by putting the handles (located on upper portion of each side) in an outward direction.

Top Compartments:
- 5 assorted bandages
- 2 packages sterile sponges
- 2 packages sterile (flats) square gauze
- 1 roll adhesive tape
- 2 tourniquets

Middle Compartments:
- 4 rolls wide muslin bandage
- 1 medium roll of absorbent cotton
- 1 medium roll non-absorbent cotton
- 2 sterile hypodermic needles
- 1 sterile box
- 4 ampules aqua
- 4 ampules pituitrin
- 2 ampules 1% silver nitrate
- 2 ampules 50% magnesium sulphate

Lower Compartments:
- 2 hot water bottles
- 1 large jar antiphlogistine
- 1 medium can of starch
- 1 stomach tube
- 1 small bottle tr. iodine
- 1 bottle arsenic antidote

# Insurance for Professional People[1]

JOHN A. LAPP, PH.D.

I AM indeed glad to speak before the American Nurses' Association again, and I am happier still that I am to speak to you on the subject of "Insurance for Professional People," for it is a subject that has been very close to my thinking for several years, and a subject upon which I have spent a good deal of time and investigation. I am not in any sense what would be called an authority on the subject. It is too vast a subject for any one to become an authority on in a brief time, but there are some aspects upon which I feel competent to express my views.

I should preface what I have to say by a brief statement concerning insurance itself. Strange, is it not, that insurance, so widely practiced, so widely bought, so widely used, is so little understood. Very few people really understand the simple principles of insurance, and yet they are indeed very simple. Insurance means merely that we collect, coöperatively, a certain sum of money, measured in advance, for the purpose of providing against a certain calamity that may happen to any one of us. It is not guesswork, it is not gambling; it is a scientific measuring of possible losses, and the gathering of funds adequate to meet those losses.

We know how many fires there will be in the course of a year throughout a large area. We know that from experience. We know what the losses are going to be. We know how much we must put into a fund if we are to pay those losses. We know how many accidents are going to take place in the course of a year. We know how much those accidents are going to cost in wages lost and in cost of medical care. We know, therefore, how much we must collect, a simple mathematical problem, to meet those losses. We know how many people are going to be sick in the course of any normal year. We know how long they are going to be sick. We know how much they are going to lose in time. We know how much medical cost, practically, there will be involved. Therefore, it is a simple matter to collect the amount necessary to meet those losses.

That, briefly, is an explanation of the simple principles of insurance. You can't get money out of a fund unless you have put money into it, and you can't pay the losses that occur unless you measure those losses and put into the fund enough to meet them.

We have four kinds of insurance that I think are of special significance to professional people:

1. Sickness insurance.
2. Accident insurance, including occupational diseases.
3. Old age insurance.
4. Insurance against death.

There are other forms of insurance useful to professional people, but not so useful as these. We might insure our bank deposits. Perhaps we haven't any. We might insure ourselves against defalcations of our subordinates, but perhaps we haven't any subordinates. We might insure ourselves against a number of other things but, essentially, to professional people, sickness, accidents, including occupational diseases, old age, and death, are the things against which we need to insure.

Looking at these particular causes of disaster, we find that they are all

[1] Read at a general session of the American Nurses' Association, June 11, 1930, Milwaukee, Wis.

measurable. We do know what is going to happen in any large group of people with respect to all these matters. We know how many people are going to die at any given age. We know how many people are going to live to old age. We know how many are going to live after sixty-five. We know about accidents and we know a good deal about occupational diseases, but not enough. We know about sickness. The losses are measurable. Therefore we can determine in advance what it will cost to meet the losses and devise the means by which these losses can be cared for.

I would begin first with respect to insurance against death, this being the least important for most of us, unless we have dependents depending solely on us. There are no great reasons for death insurance beyond the necessity of burial, for those who do not have dependents or those who must depend solely upon them.

I am not very much concerned with death insurance in my discussion here for two reasons: first, because it is not so essential to the bulk of professional people, excepting those who have dependents; second, because we have had a very considerable measure of insurance against death already developed. The magnitude of the life insurance business, as it is called, is very great indeed.

Turning to the subject of sickness insurance, we need to have a broader, a wider development. We have very little sickness insurance in this country, and most of that is limited to the people who need it least. We have practically no health insurance for the great masses of people who need it most. Yet sickness is a measurable calamity that we can determine with great accuracy.

I understand that there are about 80,000 nurses in the American Nurses' Association. Well, during this coming year, if it is a normal year, 20 per cent of the nurses in the American Nurses' Association will be sick for a period of more than seven days. Sixty-four thousand of them will escape during the entire year any serious illness. This coming year 16,000 nurses will be sick during the period of the given twelve months. They will be laid up for more than seven days. Of the 16,000 who are sick, only 35 per cent, or 5,600, will be sick for any considerable length of time. Fifty-six hundred nurses of the 80,000 will, in the course of the next twelve months, assuming it to be a normal year, have a sickness lasting over thirty days. About 500 or so will be sick for more than six months and of that number a certain percentage will be sick for more than a year, beginning sometime during the coming year.

It will be seen from these figures that the total amount of sickness is small, but it will be observed that the bulk of the burden of sickness is borne by the people who are sick for more than thirty days and especially by those who are sick for more than sixty days, ninety days, six months, and a year.

Sickness, then, being measurable, being a calamity that falls unevenly upon people, is a thing that especially calls for insurance to meet it. Likewise with accidents. We know about the extent of accidents, and fortunately we have to some degree provided for accident insurance through workmen's compensation systems. But in the case of nurses, workmen's compensation does not apply, except where nurses are employed by hospitals, or by industries, or by schools, or public departments. Nurses ought to receive compensation for all kinds of accidents and for

diseases contracted in the course of employment, from the workmen's compensation fund. But the bulk of nurses are employed by individuals and in such cases workmen's compensation does not apply. As a rule it applies only where there are three or more employees and in the case of nurses there is usually only one employee in the family where a nurse is working. So the bulk of the nurses do not get protection under the workmen's compensation law, in the case of accidents and occupational diseases, as the laws now stand.

Let me interject right here a recommendation. I do not know what the American Nurses' Association may have done upon this matter in the past, but I commend to them the very serious and systematic study of the subject of workmen's compensation as it relates to nurses in case of accidents and occupational diseases. I think as a rule it will be found that an occupational disease contracted in the hospital is considered an accident. The subject is well worthy of study because it ought to be provided, in some way or other, that every nurse, no matter for whom she may be working, whether an individual employer, a hospital, an industry, or a school, should receive compensation for that which is plainly and clearly an accident occurring in the course of employment.

There is next the subject of old age, a baffling subject. In all lines of work we find today men and women being discarded from employment and being thrown upon their own resources, to live out a lengthened time of life. We have increased the length of our lives. We live fifteen or sixteen years longer than the generation that was born only twenty-five years before us. We are going to live much longer than we do now. The number of people past sixty-five increases not only in proportion to population but much faster. There are half a million people over sixty-five years of age in the United States in excess of what there would have been if the conditions of twenty-five years ago had continued to prevail. Five hundred thousand people over those normally expected to be employed must be provided for.

I do not know how the changing conditions are going to apply to professional people, especially to nurses. The American Nurses' Association, the business of nursing itself, the professional nursing business, is not old enough to give us much of an indication as to what is going to happen in old age for the nurses. Whether or not men and women, especially women, will be employed continuously in old age we cannot tell. Whether or not the nurses will be affected as much by this change that is affecting everybody else is hard to say, but I am of the opinion that it will affect them very seriously. It is quite probable, though, that they will be able to find employment as long as their physical ability lasts, so in old age it is quite likely that it will be a problem of physical disability rather than one of employment and rather than one merely of old age.

Provision for sickness, accident, and old age is the very minimum if we are going to have that kind of security which human beings ought to have. It is a sad thing that men and women must face the kind of uncertainties that they now face. It is sad because it isn't necessary to face these uncertainties. It is possible through insurance to meet the risks of sickness, accident, and old age, meet them adequately, meet them in such a way that all may approach the future with a degree of confidence that, come

what may, they are not going to be driven into poverty and dependency.

There are at least four ways in which professional people can be insured: first, individual purchase from a private insurance company; second, social insurance through the state; third, group purchase of insurance; fourth, mutual insurance of a group through its own organization. These four methods prevail in the carrying of insurance and I should like to speak briefly about each one.

Individual purchase from a private insurance company is the method that has been generally used. One can buy almost any kind of insurance, even against bad weather. One can buy insurance against any possible calamity. But the individual purchase of insurance has two very serious defects: first, the people who need it most do not buy it; second, if they buy it, it costs too much, more than they can afford to pay. Insurance managed by a private company must provide not only for the expenses and losses but also a profit for those who are engaged in the business. Individual purchase of insurance falls down exactly where it ought to be strong. It falls down in that it doesn't reach the masses.

Social insurance through workmen's compensation against industrial and occupational diseases, through mothers' pensions, in cases of mothers having dependent children, and through old age pensions and old age annuities, is a form of insurance that is slowly but surely developing in this country. Workmen's compensation is now found in forty-five states, in varying degrees of efficiency. Mothers' pensions are now found, I believe, everywhere in the United States. Old age pensions are rapidly spreading, and are already found in at least ten or twelve states of the Union. Three of the greater states, Massachusetts, New York, and California, have recently provided for state-wide systems.

This form of insurance, however, does not meet the immediate needs of professional people, except in the case of workmen's compensation. It does not meet the needs of nurses who especially want to have, not the minimum of protection to prevent them from going into poverty or destitution, but the minimum that will make for a decent and comfortable living in the case of calamity happening to strike them.

The third method is group insurance, group purchase of insurance. This group in front of me, organized together, could go out to a life insurance company and buy for the group the kind of insurance it wanted. It could go to the insurance company and buy health insurance without medical examination, taking the members as they are, the strong with the weak, the physically fit with those who are not so physically fit, averaging all together. This group could go out and buy accident insurance, life insurance, or old age annuities for the group as a whole. They could buy anything that was wanted by a group and for far less than it would cost individually. Moreover, by buying in a group all people will be included, the weak with the strong, those who wouldn't buy it individually as well as those who would. The whole group would be in, and when a calamity happened to any one, all would bear the burden. The individual would not suffer the whole loss.

The fourth method, the method of mutual insurance of a group by itself, through its own organization, is essentially the group method carried out through a mutual plan without the aid of a commercial life insurance

company. The American Nurses' Association, or a state association, or a local association, might decide that a mutual insurance plan would be developed and that all should be protected against sickness, old age, or accident.

The four methods provide rather broadly for the insurance of professional people in those things which they need insurance for most, but, of these, social insurance, group insurance, and mutual insurance are the three most essential or most valuable in carrying out the program.

What shall we accept as our basis if we are going into the social or mutual insurance business? I am glad to note, in the report of the committee just presented, that a clear distinction is drawn between relief funds and insurance funds. Your fund today is a relief fund and not an insurance fund. As was explained, there is no relationship between the losses and the amount paid in. The amount paid in is whatever is paid in voluntarily. The amount paid out is whatever is paid out to those who are selected by one process or another for benefits. It is not an insurance plan.

If you are to establish an insurance plan for the purpose, there are certain principles that must be followed. First, rates must be adequate. You can't get something out of nothing. You can't get more out of the fund than you put in. There is no way under heaven by which that can be accomplished, and yet that has been the curse of all insurance. People have thought that insurance was magic, and that there is a fund, as some people think there is in a bank, and that all you have to do is to go and draw a check on it, never thinking that the cash must be put in before the check is drawn.

It is strange that intelligent people should not see that, but I have known scores, hundreds, of my friends from time to time in the past who have been misled by fabulous stories of what they were going to get back, little realizing that one couldn't get back more in the long run than had been put into the scheme.

Rates must be adequate to meet the measured losses that you are insuring against. If you know what sickness is going to cost, then you know that you must provide so much per member in order to pay those losses definitely upon a fixed basis.

Secondly, premiums must be automatically collected. You cannot depend upon voluntary payments by individuals of their monthly or yearly dues. If you do so depend, you must have a corps of collectors who go around continuously, as in the case of the burial insurance companies, going from door to door, collecting week by week and month by month, making certain that everybody pays, in order that if the calamity comes they may be protected.

Premiums must be automatically paid, and, in the case of the American Nurses' Association, a local nurses' association, or a state association, premiums for whatever insurance was to be carried might be collected as part of the dues.

Third, all members must be covered. If you are to have a mutual insurance or a group insurance plan, if you are to have insurance in a life insurance company as a group, or if you are to have a mutual insurance plan, then all the members of the group should be included. If they are not, you are likely to have left out just the ones who are going to have the greatest need for the insurance when sickness strikes. Moreover, it is likely that, if you do not include everyone in the group, there will be, if any process of

selection is used, by self-selection at any rate, those who are perhaps the [illegible] needing the insurance most, the most unhealthy, for instance.

Fourth, guesswork must be eliminated. There is no place for guesswork in insurance. Insurance is a scientific business and there is no need for guesswork. The actuaries in the different insurance companies work out with a nicety of mathematical precision exactly what it is going to cost under given circumstances. There is no gamble about it; there is no guesswork about it. If it is based upon guesswork, it is built upon sand. Yet it has happened in the course of time that even very able men have mistaken at this point the simple principles of insurance.

A few years ago, Andrew Carnegie provided insurance for aged professors in colleges, by creating a great fund, evidently without any consideration on the part of the men who formed the plan, or Mr. Carnegie himself, that there must be precise working out of the costs. It was demonstrated in a few years that the original plan had to be abandoned; it had to be put upon a basis of mutual support, in order to meet its obligations.

Teachers' insurance plans have been developed in numerous states and cities without any regard to what it was going to cost.

I do not suppose that I have any special call to recommend to the American Nurses' Association exactly what they should do, but there are some things that I might suggest, at least. In the first place, nurses ought to have insurance. I don't know of any group that needs insurance more than the nurses. They are in a hazardous business. They are in a business that is hard. They have certain advantages on the medical side, in that they are close to medical care. They may be able to get medical care cheaper and better and perhaps get it entirely free. They have that advantage over a great many people outside, but the uncertainties of their profession, the fact that they are not connected with any group that can be insured as a group, other than themselves, make it necessary that something be organized for them. We have, as examples, the teachers, policemen, firemen, public employees, and numerous other groups to copy from in the formation of such a plan.

Specifically, I do not think it is feasible to run a national insurance plan for 80,000 nurses scattered all over the United States. I don't think it is feasible for doctors, for lawyers, or for college professors, or any other group scattered the way they would be throughout the entire country, to run an insurance plan. It is already demonstrated how difficult it is to run a relief plan that way. It may be that it is too great a task to run a state-wide insurance plan through state associations of nurses. I cannot say, but I rather believe it is. It is certainly within reasonable expectations that a plan could be established in any given district association of nurses where the group is within range, where there is a mutual interest, where the members can protect themselves against those who might be fraudulent in their intentions, though let me interpolate here the statement that there are very few dishonest people in this world. Let me interpolate the fact that in the case of insurance there are comparatively few, so few that we can consider that it is negligible in our plans though, of course, it must be safeguarded, who would take advantage by any means of malingering.

But you say that possibly it is too

uncertain, the group is too small in a district association of nurses. Here is a suggestion concerning the organization of mutual health insurance, because for the time being that is the most essential of all these forms of insurance; namely, a local group, organized on a mutual health insurance plan, including all the members of the association within the area, that would be in some way coördinated with a state group that would form a sort of super mutual association, to protect the local associations against possible disaster through the calamities of epidemics. And the national association might use its funds for the purpose of safeguarding individual groups and state groups from financial losses and disasters, as a sort of emergency insurance.

Lastly, and here is the work I think for one of the great foundations, one of the foundations might provide for the planning of such an association; such an organization might stand behind in the experimental stages of the work to be organized; such a foundation might be prepared to help in times of financial troubles, and thus to safeguard the building up of a scheme of insurance that would be financially sound.

These are merely suggestions. Upon the one subject of insurance itself, I have no hesitation in recommending to everyone not merely that they have insurance but that they have it on a social scale, in order that the benefits of the insurance may be more widely spread. We do need to have a broad scheme of health insurance for all our people, but I think that will come only through the development of mutual and group arrangements of the different professions and organizations. We are finding it, incidentally, in the Milwaukee Street Railway and Light Company, and in scores of other organizations, where a mutual system of health insurance, including health care and, of course, the loss of wages, is provided. We need to extend that through all groups, so that the calamity of sickness will not take its toll so constantly, so that it will not continue to drive men down, to be that cause which is estimated to be something like 35 to 50 per cent of the cause of all poverty.

We know the problem; we know how it can be handled. All we need is the practical common sense to organize in such a way as to make it most economical, to make it serve us, and to make it most broadly social in its effect.

I should welcome the sight of a great body of people so intimately related with problems of health as the American Nurses' Association embarking upon this particular type of project. My suggestions are merely tentative. Your committee has been working bravely at the subject. It has come to sound conclusions, such as you heard this morning,[4] as to where you stand today. While it is not my province to recommend, I do suggest the possibility of a broader extension of schemes of insurance, gradually emerging from the health insurance side, until you have covered all the other phases of insurance, covered all the problems that make for disaster within your ranks.

[4] Presentation of the report of the Relief Fund.

# Discussion of Dr. Lapp's Address on Insurance for Professional Groups[1]

**EMILIE SARGENT, R.N.**

DR. LAPP stated that there are four types of insurance of interest to professional people: that is, sickness, accident, old age, and death; and that at present there are four principal methods of procuring these four types of insurance: through individual purchase; through state legislation, such as the Workmen's Compensation Act, and the slowly developing legislation on old age pensions; group insurance, which is purchasable by employed groups from reliable insurance companies; and fourth, a mutual insurance of a group itself, that is, where the members create their own insurance protection.

From the point of view of the Michigan State Nurses' Association Study of Insurance, our committee has put its hope and its emphasis on the education of the individual to purchase her own insurance and to create her own savings account. Dr. Lapp points out the weakness of this measure inasmuch as it fails, usually, to reach those who need protection the most. He states that group insurance reaches more of the masses and is therefore more desirable.

The Michigan State Nurses' Association has laid its problem before four or five outstanding life insurance companies. Not one has offered to insure us as a group because we do not have the employer-employee relationship which is required by group insurance.

We have not thought of entering into the fourth plan of mutual group insurance because it involves an outlay of too much money, and we are not at all sure that a professional group should build up its own insurance plan. Until some more satisfactory plan has been developed, Michigan will provide a relief fund which will be administered as any case-working agency administers relief. Thorough investigation will be made, using the local official and non-official relief organizations, when advisable, to rehabilitate the nurse who needs this type of assistance; or, if a small gift or loan of money is all that is necessary, it will be given from the Michigan Relief Fund to members living within the state.

The Insurance Committee firmly believes that the individual nurse can be interested in insurance and saving and that it is the association's definite responsibility to make it possible for her to secure information along these lines. Any state association can carry out much the same plan as we have in Michigan. We are fortunate in having state headquarters, with a full time secretary and certain helpful equipment, such as an addressograph machine. We publish a monthly bulletin which is sent out to the individual members and to the training schools. You will see that it is easy then to reach the individual member by bulletin and by letter. It is well to remember that if you have a committee, with a financial adviser, endorse four or five good savings plans and insurance plans, these companies will be glad to bear the expense of mailing their literature to the individual members of the state association. They are also glad to pay for advertising space in the bulletin; they are also willing to buy space to exhibit

[1] Given at the Biennial Convention, June 11, [illegible].

at a state annual meeting and to furnish a speaker for the program if desired. They are just as willing to send speakers to district meetings. The professional organizations are merely the means of putting the company that has a good financial plan before its nurse members. In our state, the Harmon Foundation and the Insured Futures, endorsed by the Bankers' Trust Company, have sent their literature to our individual members at their own expense.

The thought which impressed me, as I listened to Dr. Lapp's very interesting and stimulating presentation of this problem of professional insurance, is the fact that those groups which have successfully taken out group or mutual insurance, are professions wherein the largest numbers are in salaried positions; for example, the teachers and social workers; even the trades groups and the city employees, such as firemen, police force, etc., are salaried groups. In the nursing profession, 60 per cent are non-salaried workers, who collect for their services by the day and whose work is seasonal and unstable.

The question in my mind is whether or not we should try to make a plan to fit this 60 per cent, as they are the group who need protection the most, or would it be more constructive to reduce the number of non-salaried nurses? The reports from the Grading Committee all point to the fact that the nursing profession needs stability of employment. We have agreed with the Grading Committee that hospitals should employ more graduate nurses on a salary basis; that there should be nurses organized on a full-time salary basis to go into homes to give part-time nursing, or so-called hourly nursing, in our cities, and it is hoped that such a plan can be worked out even in our semi-rural communities. We probably shall always need a surplus of nurses for peak periods of illness, and if these nurses were affiliated with bureaus of nursing, now called registries, our insurance plan would solve itself, for any organized group where the employer-employee relationship exists, can take out group insurance. Likewise it is much more possible that the nurse on a steady income will be able to individually purchase her insurance and keep up her own savings plan. Therefore, when we have carried out the suggestions of the Grading Committee, the problems of our Relief Fund and our insurance question will have solved themselves. The task is in our own hands. Our alumnae, district, state association members can do much by keeping this topic alive and using every opportunity to promote it in the membership and to interest the lay people in their community to support us in our effort to become economically stable.

## How Public Schools Can Help

THE public schools can help the nursing profession by: First, acquainting the pupils with the opportunities of nursing; second, [illegible] and [illegible] those who are [illegible]; third, providing them with every opportunity to lay a broad foundation for the nursing school and [illegible] into their [illegible] the high [illegible] of personal [illegible] by the profession.

[illegible] community [illegible] and if [illegible] Conn., before the State Connecticut Nurses' Association.

# The Grading Reports Are Mailed!

RECENT visitors to headquarters have been gently led by the hand, and invited to come and peek at the Grading Committee. It has been a sight worth watching, and very far indeed from resembling anything which people usually think of as a staid statistical research office. The grading reports have been getting into the mails.

Early in May the first steps toward the actual mailing job were begun by the preparation of large manila envelopes. As will be remembered, each school had been invited to send in the names of those people whom it wished to have receive copies of the confidential report for its school. Somewhat to the consternation of the Committee, this invitation was accepted so eagerly that some schools asked not only for three or four copies, but for twenty, or thirty, or forty, and even up into the seventies. All told, there were 10,500 people whose names and addresses were submitted to the Grading Committee with requests that they be sent marked copies of the confidential report. Envelopes had to be prepared for all these people.

In order to handle this part of the job, the Committee ordered gummed labels, printed with the name of the Committee in the corner, and arranged in long strips with perforations between, tightly rolled with 1,000 labels in each roll. Typists laid these rolls behind their machines and ran them through, one label after another, without being obliged to insert each separately. As these rolls were finished, they were passed along to other groups of workers, who checked the typed address with the hand writing on the original report from the school. Only the Grading Committee workers [illegible] those superintendents who filled out their reports on the typewriter or printed the names by hand! After the labels had been typed and checked, a third group of workers tore them apart and pasted each upon a large manila envelope. All of this work had been done in May, and the boxes of envelopes have been piled ceiling high in the storage room, waiting for the great day to come when the first report would be printed and ready for distribution.

On the first morning back in the office, after Milwaukee, word came that huge wooden packing cases were waiting to be delivered. Where could the material be put? There was no space in Room 1647, for that has for months been filled to capacity with extra workers and their paraphernalia. The packing cases contained the grading reports, and the supply of blank reports for each state contained certain pages which were different from those in the reports for other states. It was, therefore, necessary to find some vacant areas where forty-nine different piles of reports could be laid out and kept separate from each other. Any one familiar with the crowded conditions at headquarters can understand the dilemma.

It was the New York State Nurses' Association which came to the rescue. "The New York nurses," said Miss Hicks, "are delighted to coöperate with the Grading Committee. We gladly offer you our floor." The offer was instantly accepted. One after another the great packing cases were wheeled down the hall and pried open. The fifteen members of the Grading Committee staff, in Indian file, made a never-ending chain, passing the packing box, picking up a bundle of blank reports, carrying it into Miss Hicks' office, placing it on the floor in its proper location, and scurrying out again for another load. Within half a

day all of the reports had been unboxed and piled, but there was practically no space left in the New York State Nurses' Association office!

The next call was for fifteen fountain pens to be loaded with red ink, for bottles of red ink, and sets of ink eradicator, the last very much in demand. A master sheet had been prepared for each school, indicating the rank of that school on each of the major items reported upon in this first section of the grading study. A special corps of workers took these master sheets and one green report book for each school. From the master sheet the worker located where each of the ninety or so red ink entries was to appear in the green book. She made the entries and another worker checked everything she did, so that there was prepared for each school one master copy in which every red ink entry had been verified. Then came the rush job. Each worker received a master sheet and a master copy, together with as many blank copies as the school had requested, and proceeded to make red ink entries as rapidly and as accurately as she could. The mailing began with schools on the Western Coast and worked eastward, in order to make the dates on which schools would receive their copies as close together as possible.

The work spread out. It is no easy matter to make identical red ink entries in, say, twenty books when the workers are sitting so close together that they hardly have elbow space. Drawing boards were brought out and balanced between desks and upon card tables, to furnish extra writing space. An appeal for an unoccupied room resulted in permission to use the little dark, unventilated cubby hole where motion pictures are sometimes shown. New electric light bulbs and a baby fan made the place habitable, and the actual filling, sealing, and mailing was transferred there. As the copies for each state were finished, inserted, and sealed, progress was noted on an office diagram in which the black portion represented how far the work had gone. As the black portion grew steadily day by day, there was mounting excitement in the Grading Committee office. Ten thousand five hundred copies is a large number. They called for 945,000 red ink entries. The stamps alone cost $1,470. The empty envelopes, packed tightly together, before they were filled occupied twenty-two large corrugated paper cartons. When filled, sixty-six mail bags were required to carry the load.

Nearly one-third of all the schools joining in the study received individual letters from Stella Goostray, who has been appointed by the Joint Nursing Committee on Educational Policies to coöperate with the Grading Committee in this work. Miss Goostray transferred her office from Boston to the New York headquarters, and has been burning the midnight oil in her determination to have her part of the material ready in time to go out with the main reports. Great cardboard cartons of Goostray letters have been carried up the long aisle from her office to the Grading Committee office, and there has been a careful matching of letters with reports.

Besides the reports to the individual schools, sample copies, with the identities of schools concealed, but marked to demonstrate the method used, have been sent to each member of the Grading Committee, to the leading nursing and hospital magazines, and to the secretary of every state board of nurse examiners. All of this work is in the last stages as this article is being written. Long before the printed copy of the August *Journal* reaches its readers, the last mail bag will have

been filled and the Committee staff will be hard at work, preparing Section 2 of the Grading reports.

Letters are already beginning to come back from schools which have been among the earliest to receive their copies. Two bewildered trustees have written, stating that they have received the reports but do not know which schools are referred to. In order to protect the identities of schools as far as possible, it has been necessary to refer to each school by its code number only, since to have red ink copies traveling through the mails or lying on desks with the names of the school written out in full, would inevitably mean that some people, who should not, would gain access to the material. Word is being sent hastily back to these trustees, telling them which schools the reports fit. One of them has reason to be bewildered, since he is trustee of three schools, all sufficiently alike in size and type so that he cannot separate the reports.

A few letters question the figures reported by the Grading Committee, the writers apparently forgetting that the results are based upon what they reported a year ago. Conditions have changed in their particular schools since. Several letters from superintendents of nurses and from hospital trustees have been written to thank the Grading Committee for its service in making available a clear and simple discussion of problems concerning the student body, and stating that the writers are waiting eagerly for Sections 2 and 3 of the report. Still other letters are raising questions as to what they themselves should do. Some of these letters are being referred to Miss Goostray for specific help. Present indications are that Miss Goostray and the Grading Committee staff will be busy women for the rest of this summer. It is hoped to have Section 2 of the Grading Study ready for consideration by the Committee early in September.

# Samples

## *From the Early Acknowledgments of the Grading Committee's Findings*

I AM impressed with the uniqueness of the presentation, with the ingenuity with which the content is assembled, with its continuity, and with its general soundness. . . . I wonder if I may have an extra copy of the report?—*Superintendent of a Famous Metropolitan Hospital.*

A jolt is the only way to describe what the report gave me, a disturbing, self-satisfaction-jarring jolt. . . . The grading is valuable, necessary, salutary and cause for heart-searching and stock-taking. We are grateful to you for it and shall hope to profit by it immediately.—*Head of a Famous School of Nursing.*

It is inspiring. It verifies the weakness we have known, and I am sure the report will be a great help in showing our directors where we fall and convincing them we need to do better.—*Director of Nursing Service.*

I intend going over it fully with our Superintendent of Nurses and then take the main points of interest before our Training School Committee, prior to submitting the entire report with any recommendations to our Board of Trustees.—*Hospital Superintendent.*

. . . while I find it of great interest I am disposed to dissent from its general findings, because I feel that the present situation with us is far better than is indicated in your analysis.—*Hospital Superintendent.*

. . . inasmuch as we are limiting the admissions to our school, and supplementing our nursing service with graduates, and nurse helpers, I am sure you will feel that serious thought has been given to the problem of oversupply from our standpoint.

Our fall class of thirty, which are fifteen less than the corresponding year of 1929, consists of four-year high school graduates from

[illegible] ... a yearly average of [illegible] ...—*Director School of Nursing.*

[illegible] ... —*Hospital Trustee.*

[illegible] ... —*Hospital Trustee.*

[illegible] ... —*Director School of Nursing.*

[illegible] ... —*Director School of Nursing.*

[illegible] therein [illegible] study. . . . [illegible] the en- [illegible] of our [illegible]—*A Nurse in Charge of a Nursing School.*

I have received a confidential copy of the "Results of the [illegible] Grading Study of Nursing Schools." . . . I am wondering if [illegible] as it seems [illegible] have no [illegible] for your [illegible]—*Hospital Trustee.*

[illegible] but I [illegible] the better- [illegible] I feel [illegible] us to [illegible]—*Superintendent of Nurses.*

[illegible] We are, of [illegible] we got [illegible] taken [illegible] made [illegible] edu- [illegible] since [illegible] that [illegible] rating. [illegible] and I [illegible] on the [illegible] in the relief [illegible].

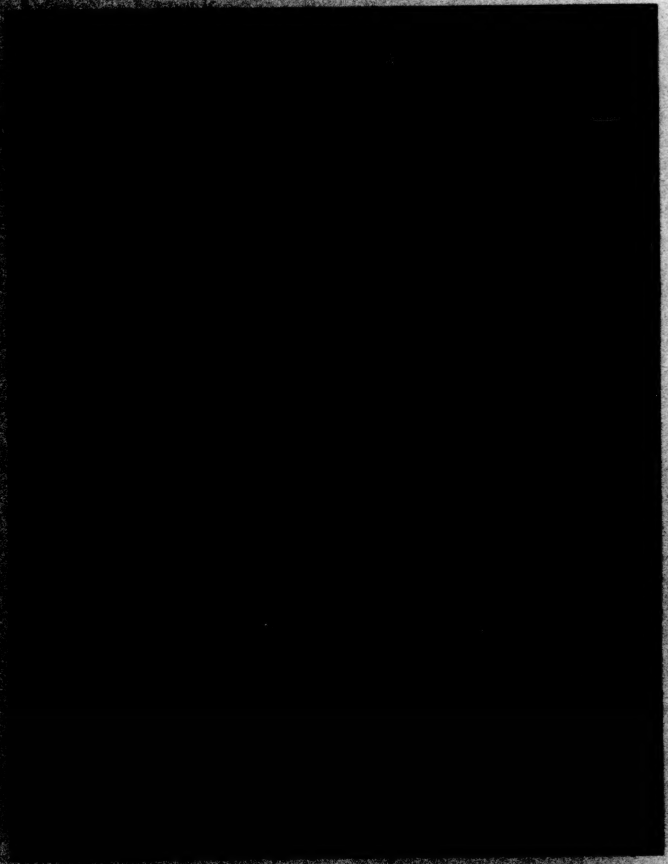
[illegible] amount [illegible] in [illegible] number of [illegible]—*Superintendent of Nurses.*

## N. O. P. H. N.'s New President

SOPHIE C. NELSON (see frontispiece) is the newly elected President of the National Organization for Public Health Nursing. Miss Nelson is a graduate of the Waltham Training School for Nurses, Waltham, Mass., and has held the following positions: Infant Welfare Nurse, Neighborhood House, Cambridge, Mass.; Director of Nursing, Boston Health League; Superintendent, Visiting Nurse Association, St. Louis, Mo. Present position: Director of Nursing Service, John Hancock Mutual Life Insurance Company, Boston, Mass.

Miss Nelson also has a record of brilliant war service. In November 1917, when the Chateau des Halles near Lyons was being made over into a convalescent home for the repatriated children of France, she went to it as chief nurse. Later, as the work of the Children's Bureau for Lyons expanded, Miss Nelson was appointed chief nurse of that district, with Dr. [illegible] as medical director. [illegible] in 1919 [illegible] of the Red Cross [illegible], [illegible] until [illegible] the last of the field nurses were withdrawn.

# Miss Loveridge Retires



AFTER forty years of arduous, [illegible] and constructive service for the Good Samaritan Hospital, Portland, Oregon, Emily [illegible] Loveridge has retired to private life. A native of New York State and a graduate of the Bellevue School of Nursing, Miss Loveridge went to Portland in 1890 to become superintendent of nurses in the first school of nursing in the Northwest. Miss Loveridge's work was truly pioneer, for the hospital of which she became superintendent in 1905 gave little promise of becoming the stately and widely useful institution it has grown to be, in its setting of fine old trees and charming gardens.

The lonely young superintendent might have been less homesick in those first months of adjustment, could she have foreseen that the time would come when the hospital world would acclaim her "a dean of hospital administrators" and would welcome her to its highest councils, and when

nurses, not only of the Northwest but of other parts of the country, proudly would do her honor.

Some of Miss Loveridge's "Reminiscences," quoted from the Bulletin of the American Hospital Association, may be found in our "Miscellany" for June, but many pages would be needed if the complete story were told. In a very real sense, Miss Loveridge became a leading citizen of Portland, or, as she modestly put it, "the hospital had large community interest." She tells, for example, how "During one year of unemployment, we aided the unemployed by furnishing one hour's work for each meal, our own employes acting as *foremen* for a given number of unemployed. We painted, calcimined, scrubbed, washed windows—did anything to give them employment enough to earn a meal."

With such a spirit of broad charity animating and directing all activities, with administrative powers that balked at nothing needful for the institution, it is small wonder that the hospital and Miss Loveridge have held the affectionate and grateful interest and support of the people of Portland and of the State through the years.

In her resignation Miss Loveridge said, in part:

Forty years is a long period, and having completed that period of time as superintendent of Good Samaritan Hospital and superintendent of the Nurses' Training School, I am desirous of retiring to private life.

It has been my pleasure to see the hospital grow from a cottage type hospital to the metropolitan proportions of the Good Samaritan Hospital today. My life has been largely woven into the fabric of the institution and it has a very dear place in my heart. It has not been an easy thing to come to a decision to give up my labors, which have been so long and so pleasant, but I feel that I should like to have the few remaining years of my life to do the things which I have not been able to do these past four decades. I intend to make my residence in Portland, although I shall leave soon for the winter in the East among relatives and friends.

The affectionate esteem in which Miss Loveridge is held by the Board of Directors, of which Bishop Sumner is chairman, is substantially shown by their provision for her future. Miss Loveridge retires on full salary. She is to be succeeded by Carolyn E. Davis, who has won distinction in the Northwest as Superintendent of the Minor Hospital, Seattle, and, more recently, in a like position at the Everett General Hospital. Miss Loveridge has the satisfaction of turning her work over to one whom she admires and has long called friend, one who brings vision, vigorous enthusiasm, and the fruits of arduous preparation to the new task.

## Miss Fitzgerald's Appointment

ALICE FITZGERALD, "internationalist," has been appointed Director of Nursing at the Polyclinic Hospital, New York City, beginning August 1. Miss Fitzgerald has had wide administrative experience both in this country and abroad. She helped to organize schools of nursing in Serbia, Czechoslovakia, and Poland, was adviser in nursing on the staff of Governor General Leonard Wood in the Philippines, and of late has acted as nurse consultant to the Siamese Government to reorganize the school of nursing of the university hospital at Bangkok.

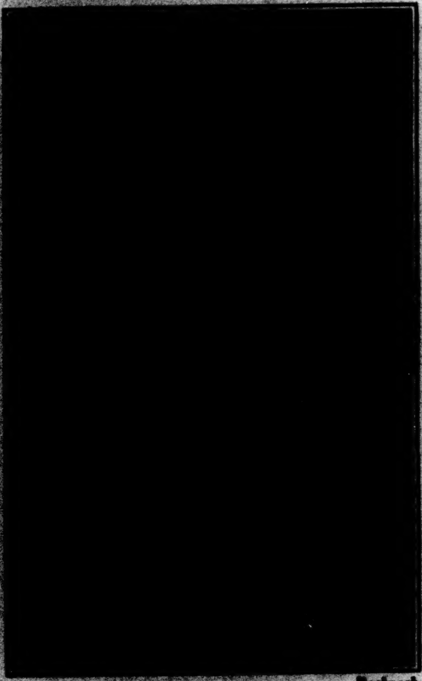
## Age of Mothers in Manhattan

SURPRISING facts regarding birth statistics in Manhattan were disclosed in a report by the health commissioner, who showed that although the child-bearing age is normally between the ages of seventeen and forty-five, in 1928, twenty-four babies were born to mothers who were children less than fifteen years of age and, equally surprising, ten babies were born to women beyond the half century mark. Of the total of [illegible] births in Manhattan in 1928, 23,270 were born to mothers between the ages of twenty and thirty.

# *Some Specialists*

## Anna L. Gibson, R.N.

MYRA B. CONOVER, R.N.



Bachrach

ANNA L. GIBSON, R.N.

It is a matter of course to hear the directors of training schools for nurses say: "We welcome the young nurse into our schools. She is so enthusiastic, so eager, so intense, so quick to grasp opportunities. It is she who blazes the new trails—trails of which the more mature nurses never dreamed." This is true in general, but some of the older nurses are still setting a high standard for the "young nurse," and outstanding among these is Anna L. Gibson, Superintendent of the Collis P. Huntington Memorial Hospital, Harvard Medical School, Boston, Mass.

Miss Gibson, as was then expected of the youngest daughter of a large family, after completing her high school education remained at home as companion and helper to her elderly mother. When she was thirty years of age, a widowed sister offered to take her place in the home, for she longed to become a nurse.

When she entered the Boston City Hospital Training School for Nurses, in [illegible], she took along her beloved old violin—a few weeks later she was an enrolled student at the New England Conservatory of Music. However, the study of music did not interfere with the study of nursing. In those days, theoretical instruction in nursing was limited, and no stress laid on case reports and so on. Nevertheless, Miss Gibson, in her daily notebooks, kept a complete record of her patients, current comments, clever pen sketches, and frequent, apt verses.

Wherever and whenever a thoroughly dependable nurse was needed, Miss Gibson was assigned to duty. Not only did she always meet that responsibility but she always found

time and opportunity to get something worth while out of it. While a charge nurse on a contagious ward when a severe epidemic of diphtheria swept the city, she volunteered on her time off duty to assist with the preparation of the "culture slides." This opened the door of the clinical laboratory to her. She soon realized that this field should be open to all nurses; that for a nurse to carry out her duties intelligently, she must have the knowledge that only a course in the clinical laboratory could give.

Miss Gibson resigned as Matron of the East Boston Relief Station, in 1914, to accept the Assistant Superintendency of the Collis P. Huntington Hospital. This was a new hospital for "research for the cause and treatment of cancer and allied diseases." Here she found a most congenial atmosphere. The doctors quickly recognized her capabilities and, as they were selected from the faculty of the Medical School, she found the various departments open to her.

Ever true to her profession, she began sharing her knowledge with the staff nurses. At the direct request of the medical profession, she started regular classes for nurses in routine clinical methods. Later, she accepted also many college graduates whose education had fitted them for this line of work. As no charts or textbooks were available for this group of students, she published her own.

During all this time she continued to broaden her own field of knowledge. She became deeply interested in the cancer problem and the study of tumors of the lymphatic system. Here, under the direction of the late Dr. Francis W. Peabody, continued under Dr. George R. Minot, one of the largest leukemia clinics in America was developed. In this work Miss Gibson took a most active part, becoming one of the best informed authorities on normal and abnormal blood cells and blood constituents. Whenever an unusual blood abnormality is found, doctors continue to seek her opinion.

Throughout all her work the importance of accurate records was insisted upon. For clinical work nothing is better than photographs. As the hospital could not afford the services of a first-class photographer, Miss Gibson mastered photography also. She follows the patient, from appearance on admission, on the operating table, or with radium applicators in position, the surgical specimen in toto, and the patient at subsequent intervals. Not only does she do this work for the hospital, but for the private patients of the staff as well.

As an executive, she is able and capable. She has kept herself informed along the most modern business lines by successfully completing courses in employment management, factory service, and other allied subjects at Boston University.

In conclusion, just a glance at the human element side. Miss Gibson is in charge of a cancer hospital. Stop and think what it means to the average patient to go to such a hospital! Miss Gibson thinks of that. Special stress is laid on the way every one from the door girl to surgeon greets and treats the patient. So far as is possible, the courtesy and friendliness of a home are found in her hospital. One example of this is the use of the hospital as a large flower garden. The plants and bulbs are supplied by the staff; Miss Gibson and her nurses, working together, care for them to the end that daily the nurses may take these flowers to their patients.

A noble life, well spent and full of inspiration is hers.

# Editorials

## *An Anniversary*

JUST ten years ago the tiny infant that grew into the present extensive, though unimposing, National Nursing Headquarters was born. Only a few nurses appreciate the courageous efforts which made that simple statement possible.

"Almost from the beginning of our organization life, the need for Central Headquarters has been talked of, first by one group of members, and then by another, but there has never seemed to be a time to begin when all the conditions were favorable," wrote Miss Palmer in a *Journal* editorial in March of 1920.

Clara D. Noyes, laboring under the Herculean burden of post-war adjustments in the American Red Cross Nursing Service, was President of the American Nurses' Association. How she found the time and the courage to pilot the association through one of the most important developments of its history no one knows. Under her leadership, and despite the opposition of the cautious and the timorous, the long-felt desire crystallized into action when the Red Cross, which had established a Bureau of Information to meet the emergent needs of nurses returning from war service, decided that it was inadvisable to continue the service as a Red Cross activity. The nursing organizations were invited to consider taking it over. After careful consideration by a committee of which Miss Nutting was Chairman and on which sat representatives of the three nursing organizations, this was done. Space was found at 156 Fifth Avenue, New York City, where the National Organization for Public Health Nursing was already established, and the Bureau was transferred from the local offices of the Red Cross. This was more than a mere transfer of function. The Red Cross provided complete equipment for the new office, financed the project for a year, and R. Inde Albaugh, who had been doing an important part of the placement service, became the director of the new office which, in addition to the placement and recruiting activities already under way, took on definite duties for the American Nurses' Association and the National League of Nursing Education. Space does not here permit a description of Miss Albaugh's heroic work for which the profession owes her a tremendous debt of gratitude for, according to a *Journal* editorial of August, 1920, the A. N. A., the N. L. N. E., and the American Red Cross were jointly represented, in the new office.

It is of particular interest at this time that this move was felt to be of urgent importance because of the need for a nation-wide recruiting campaign "*not only for the purposes of securing students, but for making better known the proper standards of nursing education and for enlisting the support of the public in maintaining them.*" The findings of the Grading Committee show how ably the first of these three objectives was fulfilled.

The report of Miss Nutting's committee outlined joint activities and suggested that there were three ways

by which the Headquarters might be administered.

1. Pooling of resources and personnel, and investing responsibility in a committee with proportionate representation.

2. A federation of the bodies concerned with a central committee which shall be advisory.

3. A combination of these two plans by which certain interests and expenses shall be shared, others handled by each association, under the direction of a committee which shall act as a Board of Trustees. This is the plan recommended.

No such comprehensive plan was put into effect, but some of the principles were made effective through the Joint Boards. In 1921, N. O. P. H. N. and the embryo headquarters, which shortly separated into A. N. A. and N. L. N. E. offices, moved to the present location at 370 Seventh Avenue, New York City, chosen because the building housed the National Health Council, with its sixteen organization members. The placement of public health nurses became an activity of the N. O. P. H. N. and later of the Joint Vocational Service. The placement of nurses for institutional positions was taken over by the League and in time discontinued. Working coöperatively on an ever increasing number of projects, the administrators of all three organizations and their staffs, and the editors of the *Journal* have consistently endeavored to work out broad gauge programs. As Miss Taylor, then Executive Secretary of the League, said in her report in 1923: "We are trying to think in terms of the big thing we represent in the project for which we exist, rather than the organizations of which we are the secretaries."

In other words, each nurse who has, or has had, the privilege of working at National Headquarters has endeavored to expand her thinking to include not only the clearly defined activities of her own organization, whichever it happened to be, but also an appreciation of the programs of the others, and to think toward an ever increasing pooling of facilities and of knowledge in ways effective for the whole profession.

The developments of the ten years have been interesting and important. The N. L. N. E. has twice moved in order to provide space for its staff, now numbering three workers, the Executive Secretary, Nina D. Gage, a secretary, and a bookkeeper. It has had three executive secretaries during this period, Miss Taylor, Miss Pfefferkorn, and now Miss Gage. Services rendered, which, because of the small staff, have to be rendered almost entirely by correspondence, fall into three groups:

1. Organization correspondence, including work for the committees.

2. Vocational guidance, particularly for a large number of prospective students.

3. A medium of exchange between over burdened educational workers, for the results of studies and experiments in the field of nursing education.

The A. N. A., from that small beginning ten years ago, now has a staff of ten professional and non-professional persons working under the direction of Janet M. Geister. Agnes Deans succeeded Miss Albaugh; and Miss Geister, Miss Deans. The Association distributed at the convention a booklet, "Your Fifty Cents," which tells of the extreme care with which every penny of income is expended and of the scope and variety of the work. For example, "In 1929, 14,040 letters were written by the headquarters staff, 2,640 pages of mimeographed material were sent to the states, 95 copies of the President's Portfolio were issued, 22 convention packages were sent to the states"—all this in

addition to extensive field work, the study of registries and other activities.

The National Organization for Public Health Nursing brought its magazine, the *Public Health Nurse*, from Cleveland and incorporated it in its headquarters activities. Ella Phillips Crandall, Anne A. Stevens, Florence Patterson, Jane Allen, and Katharine Tucker have successively directed its activities. It has a staff of ten professional and eleven office workers. Briefly, its major activities are as follows:

1. In its special field the N. O. P. H. N. continues to serve as the standard-making body and central bureau of information.
2. To individuals and agencies it offers an advisory and consultation service.
3. Special studies are conducted by its statistical department and committees.

*The American Journal of Nursing*, beginning with a small office and a part-time secretary for the editor, has now consolidated its editorial and business offices with a staff of seventeen, all under the roof of "370."

Headquarters is a friendly place where visitors are always welcome. Student nurses come in classes; graduates singly or in groups, depending on their errands or their interests; professional and other guests from foreign lands are fairly frequent, for it is not only in our own country that "370" is thought of as a center of American nursing. There are also those who come seeking special types of nurses for important posts and those who come for advice on nursing programs. Nurses come with perplexing personal problems. It is a happy task to meet such guests and many of them more than repay for time expended by offering stimulating suggestions, by indicating new developments, and, in short, by sharing experience.

Personnel and space occupied are only one means of measuring growth. The recent Biennial, with its carefully coördinated, but varied, program, was a magnificent expression of teamwork at headquarters. It is significant that the executive secretaries, instead of pausing to enjoy that success, began to work, as their trains sped eastward, on plans for extending the service in new ways and for strengthening those services already established.

These are troublous times in nursing. There is general unrest among nurses and the profession is suffering from exceedingly uncomfortable growing pains. Each day brings reports of constructive programs and of work well done. Every mail brings expressions of the difficulties to the workers at headquarters. Energetically, faithfully, zealously, your representatives toil—some of them often far into the night—to meet the needs, to help solve the problems, to make studies, to hold the profession steady on its course of ever-growing usefulness and in steady effort to maintain and improve professional standards and to assist the individual, through whatever channels may be suitable, to find durable satisfaction in her service. We cannot be too grateful to those courageous and far seeing leaders who studied the needs, made plans, and showed the way.

The officers at headquarters are not superhuman. It is not always easy for overburdened nurses to see clearly the larger implications of the task. It requires keen intelligence and generous thinking to see over the barriers of one's own organization and realize that coöperative effort is needed or even, occasionally, that a task might more successfully be accomplished under the direction of another organization. But, year by year, the quality as well as the quantity of service to the profession and those whom nurses serve increases.

At the close of ten arduous years,

with clamorous demands and urgent needs yet unsatisfied, it is important for us to evaluate the almost incalculable service to individuals, and to individuals through component organizations, that has been rendered. We pause only to acknowledge our debt to those who labored that the principle of coördinated effort might be established in surroundings which would make such effort fruitful.

The officers at Headquarters enter upon the second mile with a record of substantial service as a background, with careful plans for steadily expanding service, and with high hopes for the future. A splendid start has been made on the program outlined by Miss Nutting and her committee. What shall the next ten years show?

### *Miss Hall To Go in the Field*

AT the last minute before our pages close, word reaches us that the Board of the Peter Bent Brigham Hospital of Boston has granted Carrie M. Hall a five months' leave of absence. This is splendid news, for Miss Hall is to conduct an educational campaign for the Harmon Association for the Advancement of Nursing. She will be available for state meetings, and makers of programs should communicate with her at once. It is a rare opportunity for nurses to hear from this nurse who has devoted much time to a study of the Annuities for Nurses made possible through the Association.

Miss Hall was President of the National League of Nursing Education when Mr. Harmon, out of sympathy for nurses who seemed to him to need guidance in making their later years secure, made the proposal which resulted in the present plan. She was made Trustee of the Association and is also a member of the Executive Committee. She is exceedingly well-informed on the whole subject of economics for nurses.

As all nurses know, Miss Hall speaks with a direct simplicity that carries conviction. Her acceptance of the appointment which involves as much travel as can be compressed into five months is a matter of congratulation. Her message is a needed one. Her usefulness will be in direct proportion to the opportunities provided for her to meet nurses in groups. There is general agreement that, as a profession, nurses are not yet thinking as carefully as they should of providing for their own futures. Miss Hall is prepared to show a way.

# To the Students at the Biennial

L. L. Dock, R.N.

*WHAT message can I send to you, the younger generation? You have already had everything said to you! But, as I grow older, I realize more and more what an immense value there is in learning to preserve the romance of your lives as you go along through life. To have an eager and sympathetic interest in the human characters you meet; to store your minds with material for thought, ideals, poems and history; being interested in all sides of existence. This gift, combined, with the sympathy and comprehension of your profession, will banish dullness from the most routine tasks.*

(Some of the authors of textbooks, who had been invited to meet the students who attended the Biennial in Milwaukee, sent greetings.)

## Supervision[1]


W. H. BURTON, PH.D.


I WOULD begin by presenting a very general definition of supervision. Supervision is an expert, technical service designed to improve the efficiency of groups of workers under supervision. To teachers, the technical business of supervision is to improve the efficiency of the classroom teacher or to further the chief business of education which is the learning process in pupils. You can translate that for yourselves better than I can.

The business of supervision with you is to improve the efficiency of people in training or of those who have completed their training but are still doing technical work where oversight is needed.

I will go further and quote another definition, from Fannie W. Dunn of Teachers College, well-known in the field of education, who has defined supervision very nicely in one long sentence. I like it because it stresses the major point in supervision and then breaks it up into the ideal and the common-sense views. It is very skillfully done:

Educational supervision has the large purpose of improving the quality of instruction, primarily by promoting the professional growth of all teachers, and secondarily and temporarily by correcting deficiencies of preparation by prescriptions for teaching by [illegible].

Thus, primarily, supervision should promote the growth and the development and the better efficiency, personal and professional, of the people under supervision. Primarily it should do that. But we all know that, with the people we usually supervise, either their training wasn't complete, or they themselves are not completely up to par, and for various reasons we have to develop and correct deficiencies and to give specific directions as to what to do.

You can translate that, of course. The chief business of supervision in your field is to promote the growth of the people under supervision by any means that you can; to train them to take initiative, to take responsibility, to think for themselves, to go ahead on their own, and so on. But, secondarily, you are going to have to correct those people, to train them in service, tell them what to do, and correct them in their deficiencies.

So far I have presented general definitions. Specifically, how do we do these things? I shall give what I like to call a master definition, not because it is a master in the sense of being perfect and inviolable, but it is a master definition in the sense that it is pervasive and reasonably complete.

Supervision does four things in the main: *First*, inspection. And I stop there for just a minute to postulate that that isn't all it does. Too often

[1] Read at [illegible] session, June 12, 1929, at the [illegible] Annual Convention of the National League of Nursing Education.

that is all it does, particularly in education. I don't know how you feel about it, but the first thing that supervision does is to inspect. It has to get facts. It must know the status; it must know what is going on. I will say how in just a minute.

The second thing that supervision does is training. That is, having inspected, obtained facts, discovered the situation, its needs, its weaknesses, its strong points, then supervision plans a definite program of training for the people in the situation, the training aimed directly at the situation, at the needs and deficiences of the people. I shall elaborate on that at the end of my talk.

The *third* thing that supervision does is guidance. Some people don't see very much difference between training and guiding. I will make a distinction for you. In addition to guiding the workers, that is, in the sense of training them, telling them, directing them, it is also well always to lay plans and supervision programs for the stimulation of initiative and responsibility.

I said a moment ago, Guide the workers in trying things out for themselves. Because I do not know your work, or what you can do in this field, let me take two minutes to present a situation from education, and perhaps you can parallel it better than I can.

In the teaching *field*, in addition to training our teachers and telling them what to do, we want to stimulate the best teachers to try things out for themselves, to experiment with methods of teaching. I can see that it would be very dangerous to experiment in your field in the giving of medicines or in trying out certain treatments but, as I say, I am not sure of the details there. In education we do try to have the teacher go beyond the routine, to figure out things for himself, to express himself.

The third major function of supervision would be guidance in the sense of stimulation and encouragement of initiative, and participation, and thinking on the job.

There is a *fourth* thing that supervision does, and in the field of education this is really deep water and I anticipate it will be for you, because we can't do much of it under practical conditions. The fourth thing supervision does is to carry on a little practical research on the actual, immediate problems of the situation. I do not mean extensive pure research, such as the discovery of truth, but I do mean that the supervisory staff, be that staff one worker as an individual, or a dozen, or fifty, has as one of its inescapable obligations the obligation to do more than furnish a guide. Many problems ought to be met by carrying out some practical research procedures. Again, I can't illustrate from your field, but I can illustrate from the educational field at considerable length.

Let me go back and go over those a bit. I want to say some things about them. Let's go back to the first one, inspection. In the good old days in education, I suppose also in your field, supervision consisted of inspection. You probably have among your workers a slang term that was tacked on to those who did supervision. They call it "snoopervision." You doubtless have heard that. But that embodies a good deal of truth as regards the old type of supervision. It was a detective [illegible] it was [illegible] it was [illegible] the [illegible] an- [illegible] But I [illegible] point out that inspection, properly conceived, is still one of the most major, important, and basic functions of all

[illegible] officers, but with different [illegible] with a totally different [illegible]

[illegible] we inspect by giving [illegible] rating cards. I sus-[illegible] rating cards. We [illegible] We go around and [illegible] take a look. We inspect by [illegible], we inspect by checking [illegible] advisers, and so on. [illegible], there are four or five [illegible] data-gathering technics. You [illegible] in your field. These [illegible] to find the facts. They [illegible] to catch a worker, to [illegible], to embarrass a worker; they [illegible] to find, impersonally, the [illegible]. I mean by "sta-[illegible] work is developing, what work [illegible], and what work is [illegible] work has not carried over with [illegible] people or with all people, what [illegible] are needed in the [illegible] new equipment, new regula-tions, [illegible] adjustments of hours and [illegible], and so on. That is [illegible] today. It is operated in [illegible], fair-minded, modern [illegible] sake of coming in touch [illegible] to which the people [illegible] are working.

[illegible] of course, involves not [illegible] of your people [illegible]; it involves [illegible]—their physical [illegible] their arrangements of [illegible] distribution of duties and [illegible] responsibilities, and I [illegible] in any-[illegible] involve also their [illegible] outside of the actual [illegible] work.

[illegible] always resent [illegible] your people do, [illegible], workers do dis-[illegible] and why, very ob-[illegible] at a high level of [illegible] the job. Within rea-[illegible], fair limits, inspection extends beyond the actual rooms of the laboratory or clinic where you do your inspecting.

What is the purpose of inspecting? As I have said, to find the facts, to know the situation, particularly the weaknesses, deficiencies, and possible betterments.

That leads right up to the second major function, the training of the workers. I want to point out that, in the old days in education, visitation—visiting the workers, going to see them—was a major phase of supervision and it probably was with you. It is not major at all. It is one of the functions for finding facts. You never can supervise properly by visiting a nurse, or a clinical worker of any sort, and helping her at the time, then visiting the next one and helping her at the time, and the next one. That is patchwork supervision. It is good, to be sure, if you have nothing better, but it is random, it is desultory, and haphazard. It is not conclusive and coherent and consecutive. That is, the training program of supervision is not a haphazard affair of training this worker. If this will help him, it is good, to be sure, but I want to point out the great possibilities of organizing for a period of six months. In schools we do it on semester, quarterly and yearly basis. I mean the organizing for a long period of time of a definite program of training. Your inspectional procedure this year with the group of nurses you have now may reveal that their needs are these, and these, and these. Last year your class was particularly good in two of these points and poor in something else. Therefore, for each year, whether you divide it into quarters or six months or any given periods, you organize a program of training based upon the needs of that particular group.

I will discuss that part of my talk,

that technic of training. You directly improve the worker on the job and then you inject into the training program certain things which we may call the general improvement of the worker in service. Let me illustrate from teaching, as I know that best.

In the training program with teachers we do two things. We train them and improve them in the direct performance of the classroom acts, we give them training in the direct technics of teaching. We give them training in things other than the direct classroom technics. We give them supplementary reading. We have conferences on things not directly concerned with the actual technics but remotely concerned with them, background material; we even sometimes have to give attention to health and recreational agencies of training.

Let's go to the third thing. I am not so sure this holds for you. I am a little bit in doubt here on the matter of guidance in education. We stimulate the better teachers to take on experiments, to help us plan the program of supervision, to make suggestions as to what ought to be done in supervision.

Then in your tentative suggestions, in so far as you can, you will guide your better people to assume responsibility, to develop beyond the routine level, and to look forward to better positions and better types of work. You will pick out the better teachers and stimulate them to look for promotion, and further training, and advancement.

There is one item in guidance in education, however, which is vitally important, and which I have no doubt does apply to your field as well. One of the items under guidance in supervision is the extremely important business of developing and maintaining morale, professional spirit, esprit de corps.

As we go about the country we find many good school situations but we find in the same cities mediocre and poor school situations. We are almost ready to say, in education, that the good school buildings are always to be found where you have a fine principal at the top. Pretty nearly every time you may have very good teachers but, unless they are stimulated, led, guided, and inspired by good leaders, they only do average work. Here and there, of course, individuals stand out. In this business of developing morale, esprit de corps or fine professional feeling and spirit, the supervisory officer can contribute one of the greatest things to the efficiency of the worker and the betterment of the general situation.

How do you develop morale, esprit de corps? That is important enough for me to take a minute or two. There are differing technics for developing morale. One is, of course, to maintain a personal attitude which is fair, sympathetic, kindly, and tolerant.

I shall never forget a young woman who came to my office in tears. I was assistant superintendent in a little city. She came in with her troubles and began to cry. She cried a bit and couldn't tell me what the trouble was. I tried to encourage her to tell me what it was all about. She had had trouble with her principal, no explanation, but this is what I got out between sobs: "He bellows at me." She didn't have to say any more after that. Even if he were dead right he had no business in the principalship, and we had to tell him so.

Any group of workers, no matter if they make awful mistakes, are entitled to a courteous hearing the first time. If they repeat the same mistake, then you can be as rough as you

want to. But the attitude of the person who leads, directs, guides, helps, corrects, should be one of sympathetic understanding. That is an extremely important item in maintaining morale.

The second is this: Within the limits of time and energy, the supervisor should give help when it is needed. That poor frightened young teacher, who had caught herself in a jam, needed assistance. She needs assistance right now. It may not be the time, or it may not be the best time, for you to tell her not to get into that jam again. But help willingly and happily when it is needed.

The third thing is even more important and has a very grave implication. The third way of developing and maintaining morale is to ensure that the supervisory staff themselves know their stuff. That is, a supervisor has a difficult job. She ought not only to know the difficulties but she must know some suggestion to offer. They must really be sure on some of the things that are constantly coming to them in order to help beginners, people in training and new people. The fact that a supervisor knows, and is sure and confident, has a great deal to do with getting the support and enthusiastic following of the people under supervision.

To go back to my last point—research. As I say, that is deep water for everybody. In educational work we talk about it and we know how to do it, but we don't do much of it because we don't have the money nor the time. We are trying to do it. I suspect that in your field, as time goes on and it develops, and as you get more time and more money and more help and more equipment, you can undertake, on the job, certain minor or practical phases of experimental tryout.

People often ask if we in the professional field aren't as bad as any other. I can use an illustration in your own. I had to go to a hospital and was astounded at the professional level of nurses. I was there quite a while. It was a painful and unpleasant business, but I learned a great deal and I had a lot of fun.

I was staggered by some of the leading physicians in the hospital. One of them used a new instrument to remove tonsils. He showed it very proudly around the staff room. One or two of the older surgeons, men of consequence, wouldn't look at it at all. One said, "I have been doing it this way for twenty-five years, and it has been quite successful, and I am not going to fool with anything else." Needless to say, he didn't do any operating on me.

I was astonished, but we are just as bad in teaching. The worst thing you can do is suggest to an old-timer something that has come from a scientific laboratory, because she knows it is wrong before she has tried it. I wonder how many of these practical school administrators know this new education is wrong and are sure it is wrong. I wonder how they know, because they never tried it out.

To go back, in your field you can try out some of the new things. Where it is dangerous, it is going to get you into trouble. You can try some experimental technics, you can try out new things. I can't talk your language very well, but, at least, I can stress the research point of view.

To summarize: The functions of supervision are to inspect the situation. On the basis of that, to give the workers guidance, which is merely direction, training, help, and assistance; then guidance in the sense of stimulation. And, lastly, do such research as you can.

I want to develop four other points

which contrast traditional, old-time supervision with modern, scientific supervision. There are other points; these are the four most important, to my mind.

In the first place, modern supervision is not confined to visiting and conferring with the worker himself. Supervision today is an extensive, complicated, and far-flung program, involving many things beyond visiting the worker.

As I pointed out earlier, visitation will get you into a round of patchwork and of random and desultory supervision. Mark well, lots of it is good, it is very helpful at times, but the help is not continuous, but piecemeal.

Supervision today rests upon a planned program of objectives and means of attainment.

I want to make this second point. Traditional supervision was inspection. Today it is help and assistance and encouragement.

The third contrast (and I am sure this holds true for you as well as it does for us) is that traditional supervision was usually done by one person. Today in education, from two to twenty people may supervise a given group of workers. And I think, from what little I know, you ought to have several supervisory contacts. Two or three judges are better than one, and two or three instructors, or two or three people planning, training, and guiding, are better than one. Let me put it this way: Traditional supervision is usually done by one person; modern supervision is usually a cooperative undertaking of two or more.

The last and fourth contrast in points that I will make is this: Supervision is not imposed from above. It is not authoritarian. Mark well, it directs from above when it has to. There must be authority up there, but supervision develops out of the situation, supervision develops out of the need of the workers under supervision. It is not imposed from above by a staff, but it is based on what the staff finds in the actual situation.

These are the four points I wanted to make. I did not have to bring them out a great deal in detail, but I mentioned them for the sake of emphasis, and perhaps it may clear up one or two points for some of you. I assume that most of you in this audience accept supervision; that is, you don't argue about it. You believe in it, in the main. In education, as you know, until just recently we have had to fight for supervision. In this decade it is all right; we get by with it now. But until recently supervision was under fire, under suspicion. To the word "supervision" teachers were very antagonistic. Many of the old-timers still are.

I want to develop three or four reasons why supervision has taken hold.

In the first place, supervision is an accepted business principle in any complex human undertaking; that is, any undertaking in which several people work together needs unification and coordination. It is quite natural for people to differ in the way they do things, in the way they envisage the end, in the way they think of achieving these ends. In complex and important business it is necessary that somebody be responsible for unification and coordination. It is an accepted business principle.

One of my graduate students brought in, the other day, a set of score cards from a dairy company which distributes milk and dairy products all through this region. They have score cards just as we do. They have rating cards, they have inspectors, they have little booklets that tell how they improve the morale and efficiency of their

workers on the farm or wherever it may be. They have supervision.

Some years ago, in Cincinnati, I had an interesting experience in renting my house for the summer to a gentleman who came there to be the head of one of the life insurance agencies. I turned over my home to him and told him, of course, to use anything there was in the house. In looking around the place he found some books on supervision. As it happened two or three of them were mine. I did not think he would read them. In fact, I thought he wouldn't. He picked one of them up during the summer, and when I came back three months later he told me, very proudly, that he had presented to his company an organized plan of administration for a supervising agency, for insurance agents all over America. He presented it to the home office in New York and, with some modifications, the plan was adopted. It is now in use in that insurance company all over America, and others follow it.

The point I am making is that supervision is an accepted business principle in many business corporations. The trained nurses and even the physicians have some sort of professional supervision, though it isn't of the rigid sort that we have.

The second is that among educators, the workers in business fields are presumed to be on a level with nurses. I suspect that the best trained nurse is undertrained in this country still. The best trained in all these fields is undertrained, in terms of an ideal, so that supervision is necessary, because the average worker in any field is not a highly trained individual.

The last reason I would give is particularly true in education and I suppose it is with you, too; that even if the teacher were trained, she could not keep up with the new developments in the field. In education no school teacher could attempt to keep up with the developments in the science of education. She has to have an agency, a supervisory staff, which reads, digests, and corrects the new material to the level of the classroom worker.

That is enough on supervision, its functions, the contrast of the old and new, and the reasons for it. I am going to break away from that and present my last point.

In this connection I have mentioned several times the fact that supervision should be a planned program. Let me go through it rapidly. This is too good a point not to repeat. Supervision is not visitation. It is not helping this worker and this worker and this worker, though that is good. It is the planning, in advance, things to be done over a period of several weeks or several months.

The first thing to do is the inspection I have been talking about. Then, having inspected the situation, you make a list of all its needs. They may be deficiencies in the training of the workers, they may be new departures that should be injected, they may be corrections of procedures now being used. Whatever they are, make a long list. We pick out from that list, two, three, four or five (not more than four or five) major items and make them objectives. We may inspect a school and find that the children are below par in both speed and comprehension in arithmetic, speed in reading, or in both speed and knowledge. We have definite tests. A child in the fourth grade should be so good in speed. He should read so fast, and be able to comprehend completely a certain per cent of the material. We naturally test, and ordinarily children will be up to par if there isn't something the matter. You have to plan a

perfectly definite program to eliminate that difference, when they are found deficient. In another section you may find that a whole school of children is prone to use certain language errors. You have noticed in your own everyday experience that in certain localities certain language errors are common. Everybody uses them. At least there are certain deficiencies of grammatical construction.

In the old days we used to say: "We will give him more reading, give him more of the same." We don't do that any more in education. If a child can't read, we find out what is the matter. Very often it is the kind of book or choice of material. We diagnose the case (that should be a familiar word with you) and then we prescribe. And, by the way, that is the very term we use in the field of remedial teaching. After we have diagnosed the case, we plan a program for remedial teaching. You see what I mean. We find out the books that are useful and we prepare them in advance and talk about the material in the book. It is of no avail to hand out books and bulletins and then have everybody meet and talk about them, but we talk about them in advance of the bulletins. We have group meetings and so on. We do a great many things like that. We actually check back to see if we got it right.

The great difficulty of educational supervision has been until recently, I think, that we set up a grand program of supervision, issued bulletins, and read some books, and had lots of fuss. At the end of the year we checked up and found that some children are better, but that some are badly taught.

I remember a youngster who lived down on the shore where we were spending the summer. He played with me as a boy. We had great sport making a mark and shooting at it. He was a very much better shot than I was. It irritated me a great deal and was very annoying. I couldn't shoot as well as he did, until I got wise to his system. Then it was nip and tuck. His system was this: He always announced what he was shooting at, after he had shot.

In the school business we have a little of that, but not much. We have principals and superintendents who issue annual reports pointing out what they have done. It is much better to set up a supervisory program earlier in the year and say, "We are shooting at that," and then go back and inspect it and see how well you have progressed.

I have tried very briefly to present to you the four major functions of supervision, certain points of contrast between traditional and modern supervision, and to emphasize the necessity of a planned and organized program of supervision so that you can carry on continuous work with the people you are supervising throughout the period involved.

# Supervision of Clinical Instruction[1]

MARY M. MARVIN, R.N.

THE first problem with which one is confronted in this discussion is that of defining the scope of clinical instruction. Is clinical teaching limited to the teaching which takes place in a hospital ward or does it also include the teaching of the nursing classes following the physician's lectures?

Supervisors of departments like the pediatric and surgical, who are familiar with the ward activities, ought to be the best prepared to teach the nursing classes related to these specialties. If these classes are well correlated with the work of the wards and are taught by the heads of the special departments, should clinical teaching not include the teaching of the clinical nursing subjects as well as the teaching in the ward? If this were done, there would be two distinct groups of clinical teachers, the supervisors and the head nurses.

To distinguish between these two positions, the definition stated in the 33rd report of the National League of Nursing Education will be used:

> In order that all should have the same meaning of the terms supervisor and head nurse, it was decided to call a graduate nurse who was responsible for two or more wards in care of [illegible] nurses, a supervisor, whereas a graduate in charge of a smaller unit would be referred to as a head nurse.

There are many reasons for the prevailing interest in more systematic programs of ward teaching which it would be well to review at this point. First and foremost, the hospital wards, the laboratories of the nursing schools, are the only places in the world where students, through long continued practice, can acquire the art of nursing. This in itself makes an adequate supervision of the practical work imperative.

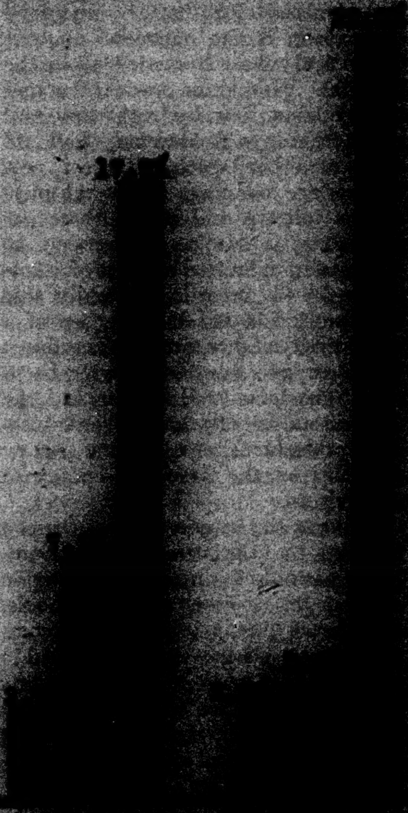
Another factor which has influenced the demand for better organized supervision is the increased amount of medical research carried on in the hospital. Numerous new cardiac and kidney tests, new hydrotherapy and psychotherapy treatments, and all sorts of other special medical procedures are evolving. Although physicians initiate and direct these experiments, it has been necessary to delegate an unlimited number of exacting tasks to nurses. Naturally this has resulted in the building up of a whole group of new nursing procedures which are necessary in carrying them out. The increased number and the delicate nature of many of these tests and procedures are making heavy demands on the time and energy of supervisors.

Along with the growth of American hospitals and the increase in the number of patients has come the admission of younger women to the schools. Because of this, a vigorous and competent type of supervision is needed in taking care of patients and providing satisfactory service to the physician. That is not all, however. During the period when immature undergraduates are forced to assume difficult and taxing responsibilities, the school is under obligation to give them protection.

Still another stimulating influence in improving supervision may be attributed to the better qualified administrators and teachers. They appreciate that the best results from classroom instruction can be brought about only through coördinated plans of ward teaching.

[1] Read at a general session of National League of Nursing Education, [illegible]

[illegible]



[illegible]

[illegible] the [illegible] of [illegible] head [illegible] well [illegible] are [illegible] have [illegible] that [illegible] program [illegible]

[illegible] pro- [illegible] are [illegible] of [illegible] be [illegible] an [illegible] several [illegible] jobs at [illegible] one [illegible] positions [illegible] collecting [illegible] partici- [illegible] Of the [illegible] around [illegible] re- [illegible] this [illegible] represented [illegible] and [illegible] which [illegible] or a [illegible] months. [illegible] number [illegible] records [illegible] safe [illegible] by [illegible] work [illegible] good [illegible]

[illegible] by computing separately all the [illegible] each day of the week and deter- [illegible] for example, the [illegible] spent in taking and giving [illegible] and finally, the amount of [illegible] giving and taking reports all [illegible]

[illegible] the amount of time spent [illegible] of each function for the [illegible] week; for example, the time [illegible] head nurses or all supervisors [illegible] reports for the week. [illegible]

[illegible] these calculations to show [illegible] of the individual who [illegible] the one who spent the [illegible] the percentage time [illegible] of each group.

[illegible]

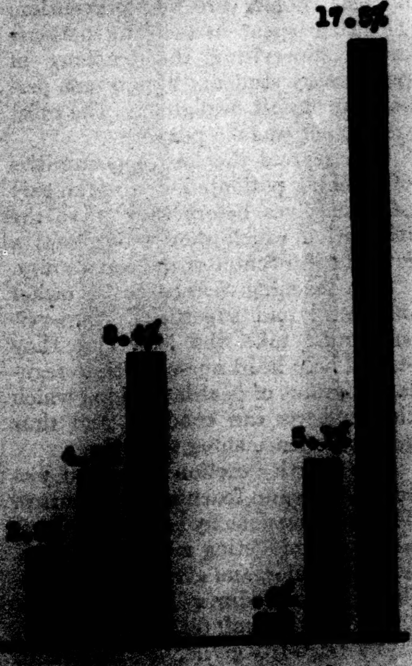
[illegible] activity mentioned first was that of nursing patients. This consisted of giving baths and enemata, [illegible]

[illegible] activity mentioned was [illegible]

housekeeping. It consisted of inspecting equipment, cleaning the office, taking inventories, supervising the cleaning done by maids and orderlies, checking up and ordering household supplies, setting up standards for various kinds of ward supplies, and the like. The time spent varied from 3.5 per cent to 17.5 per cent. Some aspects of housekeeping are essential in the efficient supervision of a department, but many functions mentioned might better have been done by maids.

The third activity mentioned was supervising and teaching patients.

Time Spent by Head Nurses and Supervisors in Housekeeping Duties. Low, average, and high percentages are shown.



Time Spent by Head Nurses and Supervisors in Teaching and Supervising Patients. Low, average and high percentages are shown.

The latter included instruction in matters related to diet, personal hygiene, home care and prevention. The time spent in teaching patients or in supervising the teaching of patients by students by any one person was almost negligible. The most time spent was 6.5 per cent.

[illegible] the lost opportunities of teaching patients how to take care of [illegible] before they leave the [illegible] which should represent a [illegible] center of the community. [illegible] seemed to be rather [illegible] [illegible] they should help head nurses [illegible] of health [illegible] the [illegible] [illegible]

[illegible]

[illegible] nursing classes. Thus, in reality, most of the ward teaching was done by head nurses. The time spent in teaching ranged from an average of one-half hour per day on the part of one individual, .03 per cent, to over four hours per day on the part of another, 31 per cent. How interesting and enlightening it would have been to have known the quality of nursing care given to patients in those two situations. It is likely that well directed teaching in the ward is consistent with treatments given properly and on time, completely recorded as a result of intelligent observation of the reaction of the patient.

It is gratifying to know that in some cases the wards are really functioning as nursing laboratories where a teacher spends a third of a whole week guiding the activities of the students.

The fifth and sixth activities mentioned were concerned with the work of supervisors and head nurses taken separately. Rounds made by a supervisor seem plausible until one analyzes the day's work of the individual and finds that it does not include rounds with the physician nor rounds for the purpose of supervision of the student nurse's work. When the head of a whole department spends one-fifth of her time for an entire week in this way, one must challenge the soundness of the supervisory plan that allows it.

One wonders what these trips called "rounds" [illegible]

[illegible]

[illegible] program, on the other [illegible] is in reality the whole heart [illegible] supervision. It is the test [illegible], as well as the art side [illegible] and calls for systematic [illegible] in order that the supervisor [illegible] in close touch with the [illegible] proceedings in her de[illegible].

[illegible] activity mentioned was re[illegible] by head nurses who spent [illegible] and one-half hours in one [illegible] to thirty-five and one-half [illegible] another, writing reports and [illegible].

[illegible] causes of this perni[illegible] are: inefficient manage[illegible] the part of head nurses who [illegible] sorts of daily sheets and books [illegible] or, on the other hand, [illegible] "red tape" on the part of [illegible] that requires an inordi[illegible] amount of clerical work from a [illegible] staff. To correct this, mimeo[illegible] or printed sheets, such as [illegible] for requisitions, inventories, [illegible] slips, assignments and treat[illegible] sheets would curtail much of the [illegible] writing and, at the same time, [illegible] a great deal of time and energy which could be put to better [illegible].

[illegible], this limited analysis re[illegible] some interesting facts about [illegible] two positions. In certain in[illegible], supervisors who were heads of [illegible], and head nurses in [illegible], were doing practically [illegible] work and the supervisors [illegible] to be on a distinctly [illegible] level.

[illegible] to find so little [illegible] in the time spent by the [illegible] of the two groups in the im[illegible] [illegible] and [illegible]. The av[illegible] [illegible] only [illegible] per [illegible] whereas [illegible] 14 per

Time Spent by Head Nurses and Supervisors in Teaching and Supervising Nurses. Low, average, and high percentages are shown.

[illegible] is accepted for the position. [illegible] her new duties are to [illegible], nursing and management [illegible] as teaching.

[illegible] briefly, the analysis [illegible] the first plank in the program [illegible] supervision is the analysis, [illegible] reorganization of the work [illegible] in order that there [illegible] groups of workers on [illegible] levels, one the head-nurse [illegible] the supervisory.

[illegible] schools earnest efforts are [illegible] to improve the supervision [illegible]. Some of the [illegible] are:

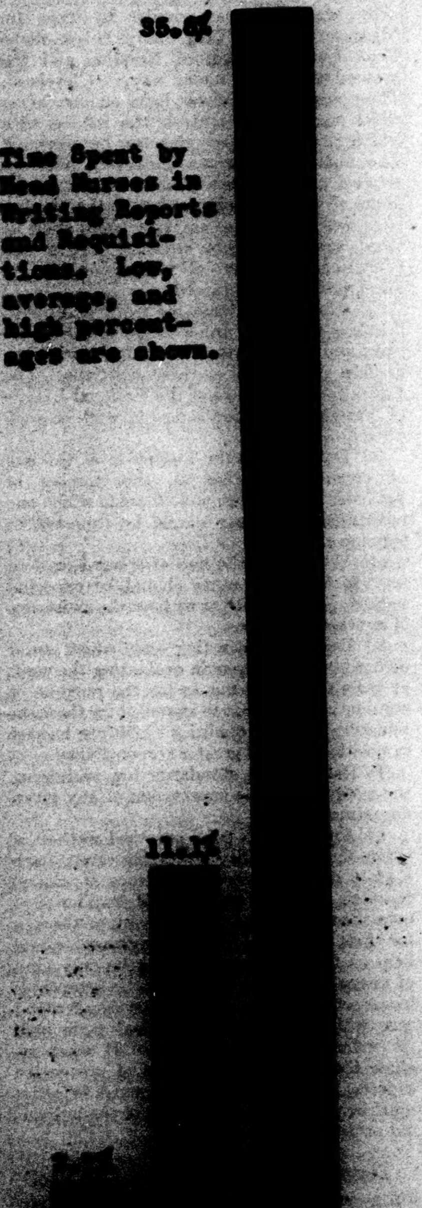
[illegible] The employment of a sufficient number [illegible] to ensure good nursing [illegible]. This is basic.

[illegible] of programs of staff [illegible] the general duty group, to make [illegible] to the hospital employing [illegible] at the same time to make them [illegible] giving them an opportunity for [illegible] and professional growth.

[illegible] an opportunity [illegible] in the selection of new members of [illegible] staff.

[illegible] further the "in-service" [illegible] preparation of head nurses, [illegible] of these nurses [illegible]. These programs may include [illegible] plans for the introduction of new [illegible] similar to those now [illegible]. There would be several [illegible] of a plan. The new [illegible]

[illegible]



(a) [illegible] [illegible] Cook County School of Nursing, and the [illegible] Cleveland. [illegible]

(b) [illegible] [illegible] of the National League of Nursing [illegible] is now at work on such a study.

(c) [illegible]

(d) [illegible]

(e) [illegible]

(f) [illegible]

(g) [illegible]

These are only a few of the problems [illegible] nursing education.

## Work of National Leprosarium During Past Fiscal Year

A REPORT [illegible] that during the [illegible] year of the National [illegible] by the Public Health Service [illegible] new patients were admitted. There was an average of [illegible] patients in the [illegible] during the year. [illegible] as no longer a menace to the public health. Six [illegible] requirements [illegible] deformities and [illegible] which could not be [illegible] in the [illegible] to the hardships and [illegible] frequently [illegible].

The [illegible] of the [illegible] patients of the [illegible] Louisiana and [illegible] of any of the [illegible] born in Ohio. Of the [illegible] during the year, California [illegible] Louisiana [illegible] Texas with [illegible], and [illegible].

Chaulmoogra oil, by mouth, was used as [illegible] for [illegible] patients, the dosage ranging from [illegible] drops daily. One hundred and [illegible] patients are taking hypodermic injections of [illegible] derivative of chaulmoogra oil. Dental work has been [illegible] as necessary. [illegible] and [illegible] treatments [illegible].—From *Health News* of the U. S. Public Health Service.

A Correction.—In the June *Journal*, [illegible]

## California To Require High School Graduation

THE [illegible] Board of [illegible] effective [illegible]

# Department of Red Cross Nursing

DEPARTMENT EDITOR: CLARA D. NOYES, DIRECTOR NURSING SERVICE, AMERICAN RED CROSS

## *Around the World with the Red Cross Nurse*

FROM Elsie Jessup Waring, [illegible] American Red Cross nurse, Lagos, Nigeria, B. W. Africa, whose husband is connected with the Nigerian Railroad, we received the following interesting story:

[illegible] years ago, while in the "bush" with my husband, I had a nursing experience which I thought might be of interest to you. We were [illegible] miles from the nearest hospital or doctor when a violent epidemic of influenza broke out in the native town of about 3,000. It was in the country of the Emir (or Mohammedan) rulers and, as you know, their [illegible] of women is not a high one. My first patients were workmen of my husband's, who were sent to me by him for medicine. I had nothing on hand but Epsom salt and iodine, [illegible] an S.O.S. to the hospital, and they very generously supplied me with Stokes' [illegible] and liquid quinine, within a few days. Our bungalow consisted of two rooms and a large verandah, and the latter became my [illegible] dispensary. Every morning there were between fifteen and twenty natives squatting on the floor, coughing, waiting for the "Madame" to help them. Also wives and babies eventually came, after they found that the [illegible] white woman had helped the men. [illegible] day my house boy ran to me in the [illegible] in great excitement and said, "The [illegible] he come, Ma." I looked out and there [illegible] did not seem to worry him at all. He passed them over to one of his followers to carry and, after many salutations and thanks, the party moved off, mounted their horses, and disappeared in a cloud of dust. A few days later, the same crowd appeared, and the old Emir came in to thank me for his recovery. The Political Officer of the District said it was almost the first time a Mohammedan African Chief had applied for help to a woman, so I felt duly proud, especially as I was American! This happened in Northern Nigeria at a place called Kafanchan.

A later letter tells of life at Lagos:

My husband is at present stationed in Lagos, and the medical department is capable of handling their "end" without my poor volunteer assistance, although there is a child welfare center opened and I'd love to get into the middle of that, if they would allow it.

The Rockefeller Commission has a very extensive group of doctors here, doing research for yellow fever. Dr. Beeuwkes is in charge and is very popular with all the British residents as well as his own people (Americans).

At present, a few miles from Lagos there is a pest of locusts destroying the vegetation and, in some places, the entire population has been ordered out to dig trenches and burn the young ones as they hop along. Motoring a few days ago, we came to a part of the road which was black with the young locusts, all jumping about like grasshoppers. Unless the young ones can be destroyed, there will be a serious shortage of crops this year. The farmers had a hand-to-mouth sort of existence at the best of times, so we are all praying that nothing will happen to make their crops fail entirely.

Lady Thomas, our Governor's wife, has started "The Ladies League of Nigeria" and a number of European women are trying to teach the native women and girls to sew. (It is an unwritten law that we never allude to ourselves as white and the others as black. It is always European or native.)

I am teaching two of these classes a week and Lady Thomas has asked me to give some lectures on hygiene to the girls. She is very

[illegible] would be light for them.

Needless to say every effort will be made to comply with Mrs. Waring's request.

Alice Carr, American Red Cross [illegible], writing from Athens, speaks of Miss [illegible], who visited the United States last summer. She will be pleasantly remembered by her many American nurse friends.

[illegible]

[illegible] will [illegible] and of [illegible] look [illegible] and [illegible] of [illegible] we [illegible] almost [illegible] pro- [illegible] girls. [illegible] and [illegible] we [illegible] that [illegible] have [illegible] class [illegible] amount [illegible] There was [illegible]

[illegible] kindly [illegible] any- [illegible]

[illegible]

[illegible] There never was a [illegible] better [illegible]

Miss Carr also tells of many other interesting people, places and problems.

[illegible]

[illegible] However, during the past year [illegible] have been numbered the [illegible], head of the Hindu [illegible] and also the sister of one of [illegible], the wife of a government [illegible] officer, who was on tour but [illegible] his wife was to go to the Mission [illegible].

[illegible] are required to care for [illegible] when they are eligible to sit for [illegible], we are not only [illegible] real service to many women in [illegible] of need, but during the past year [illegible] been necessary to send any nurse [illegible] her nursing of cases as was [illegible].

[illegible] Rohrer, a graduate of [illegible] Hospital School of Nursing, [illegible] member of the Red Cross [illegible] Service, writing from the [illegible] Hospital, Zamboanga, Philippine [illegible], of which she is Superintendent, [illegible] an interesting account of [illegible]. Mrs. Rohrer's husband is a representative of the Standard Oil Company at Zamboanga. The [illegible] being without a superintendent, she consented to assume [illegible] the responsibility of this office. She has found it impossible [illegible]. We quote the following [illegible]:

[illegible] is the capital of the Province of [illegible] and is the [illegible] port for [illegible] portion of Mindanao. It [illegible] of about [illegible].

[illegible] the Philippines [illegible]. On the [illegible] known [illegible] since Bishop

Brent's death) was formally opened February 7, 1914, and that the ceremonies were conducted by Bishop Brent. In the addresses by different people it was especially emphasized that the animating spirit of the hospital was essentially humanitarian, and its purpose was to minister to the sick and suffering of every race, sect, and creed. These assurances, then made, have been strictly adhered to and are as true today as when made years ago.

In spite of the fact that the hospital has been handicapped by too frequent changes of personnel, it still remains true that valiant service has been performed for all sorts and conditions of men. At present the hospital has a resident Filipino physician, graduate of an American College. There are also six graduate nurses from Manila, and much is being done to bring the hospital service up to a high standard. (The six nurses are natives trained under Americans.)

### *Enrollments Annulled*

THE enrollments of the following American Red Cross nurses have been annulled, but their appointment cards and badges have not been returned. It is to be noted that appointment cards and badges always remain the property of National Headquarters and their return is requested when enrollment is annulled: Celia Evinger; Mrs. J. Feagin, née Gladys Marie Hamilton; Hazel Agnes Falls; Oliver Mary Falls; Katherine Farr; Ina Leslie Fawcet; Emma Ferguson; Jean Clark Ferguson; Alice Edna Fielden; Mrs. Henry Fisk, née Bertha Louise Wheeler; Carrie B. Fisher; Marion Flint; Mrs. Margaret T. Foley, née Holleran; Floyda Elizabeth Foreman; Mabel Ruth Fossbinder; Mrs. J. W. Fountain, née Vennette Irene Miller; Gladys B. Fowler; Esther Fraser; Elizabeth B. Friedman; Mrs. H. D. Friend, née Erba Ann Dillman; Flossie Belle Frost; Mrs. Gardner Royal Fryer, née Smith; Mrs. J. R. Gibbons, née Lois Lillian Lazive; Artie-mishia Glaze; Stephania H. Glover; Mrs. Adelaide Marguerite Glendening, née Clancy; Mrs. J. D. Glenn, née Katherine Lucy [illegible]; Mrs. Viola Louise Goodman, née [illegible]; Mrs. [illegible] Gordon, née [illegible]; Mrs. [illegible] C. Grant, née Agnes Josephine Green; Belle Margaret Granger; Frances Jane Green; Mary Green; Mrs. Helen Angela Greenly, née Elward; Mrs. Allen S. Grew, née Elizabeth A. Nyhan.

# Our Contributors

Our leading article demonstrates the high quality of Anne L. Gilbert's work, although the subject is "a tremendous one and difficult to write about in non-technical language."

Burton J. Lee, M.D., is Clinical Director of the Memorial Hospital, New York City. (See "Nursing Care of Cancer Cases" in July *Journal*.)

The article by Florence K. Root, who is Dean of Women, Wooster College, Wooster, Ohio, is timely and should be helpful to directors of schools of nursing.

The timely article, "Two Common Diseases of the Skin of the Feet," is a fine example of coöperation between the author and her "chief." Mrs. Florence S. Moss, R.N. (Army School of Nursing) is employed by Dr. H. H. Hazen, a specialist of Washington, D. C.

Ella M. [illegible], R.N., M.A. (Children's Hospital, Boston, and Teachers College, New York) has had a varied experience, including that of visiting instructor.

[illegible] is the registered pharmacist at the Christian R. Holmes Hospital, Cincinnati, Ohio.

E. I. Erickson is the efficient and sympathetic Superintendent of the Augustana Hospital, Chicago, Ill.

Florence M. [illegible], R.N. (Augustana Hospital School of Nursing) is and has for several years been a private duty nurse. She has a rich background of experience in both institutional and public health nursing.

Mary Margaret [illegible], R.N., is the executive secretary of the Minneapolis Official Registry. (See "How One Registry Handles Its Work" in the January *Journal*.)

Lena M. [illegible], R.N. ([illegible] School of Nursing and Hospital) is a private duty nurse. [illegible] of the Private Duty Section of the District, and is a member of the Board of Directors of the Official Registry, [illegible].

[illegible] A. [illegible], R.N., is a private duty nurse who takes an active and constructive part in professional activities in Louisiana.

J. Beatrice Bowman, R.N., Superintendent of the Navy Nurse Corps, knew that all nurses would rejoice over the "step in advance" she describes.

[illegible], R.N. (Kahler Hospitals School of Nursing) is doing group nursing at the Kahler Hospital, Rochester, Minn.

Hester Viney, S.R.N. (See April *Journal*) was a lecturer at the College of Nursing, London, when she prepared the article on British registration for us.

We are indebted to [illegible], R.N., M.A., the able Director of the School of Nursing of Highland Hospital, Oakland, Calif., for transmitting "An Ambulance Emergency Kit," written by Margaret [illegible].

John Lapp, Ph.D., Professor of Sociology at Marquette University and an unusually interesting and able speaker, held the intense interest of a large audience at Milwaukee, when he spoke on "Insurance for Professional People."

[illegible], R.N., B.A., is Superintendent of the Visiting Nurse Association, Detroit, and is the President of the Michigan State Nurses' Association, which has been studying the problem of insurance for nurses.

Because many nurses have wondered "how the Grading Committee spends its money," we asked Dr. Burgess to describe the actual work of her office. However, nothing but a visual image of that staff, working elbow to elbow, really tells the story of intense activity.

[illegible] B. [illegible], R.N., A.B., is Superintendent of the New York Skin and Cancer Hospital. Her own unusually fine training and experience qualify her to appreciate Miss Gilbert's work.

The paper by Dr. V. E. Hurley, Professor of [illegible], University of Chicago, was [illegible]

Margaret [illegible], R.N., is Operating Room Supervisor at the Akron City Hospital, Akron, Ohio.

# Student Nurses' Page

## Anatomical Correlation Study

**WILNA SLAPAK**

*Cook County Hospital School of Nursing, Chicago, Ill.*

*(This is one of the studies made after the completion of the anatomy class work and after students are assigned to full time duty (third quarter) on the wards. It is an example of correlation of theory, as taught in the classroom, with practice as found on the wards, under the direction of Ella Best, Instructor in Anatomy and Physiology.*—EDITOR.)

| Region Involved | Condition Observed | Outstanding Treatment |
|---|---|---|
| I. *Lower Extremity* | | |
| 1. Foot | a. Dry diabetic gangrene of little toe, left foot. | a. Amputation of toe, dry dressings. |
| | b. Dry gangrene of left foot with progress to knee, probably arteriosclerotic. | b. Ligation of femoral artery, to allow self-amputation. |
| 2. Fibula | a. Fracture of lower third of fibula. | a. Posterior molded splint, bed rest for a few days. |
| 3. Fibula and tibia | a. Tuberculosis involving tibia and fibula of left leg. Incurable. | a. Bed rest. |
| 4. Patella | a. Fracture. | a. X-ray, cast, complete rest. |
| | b. Arthritis deformans involving knee joint and bones above and below. | b. Bed rest, cast, medications. |
| 5. Femur | a. Fracture of lower third. | a. Cast, sand bags. Later use of crutches and caliper. |
| | b. Fracture of neck of femur. | b. Sand bags. No cast because injury irreparable—patient 92 years old. |
| | c. Fracture of neck of femur. | c. Reduction. Extension with weights. |
| | d. Contusion over right trochanter. | d. Dakin's dressings. |
| 6. Fascia of internal surface of thigh | a. Cellulitis with ulcer. | a. Continuous hot dressings, Dakin's irrigations of wound. |
| 7. Dorsal surface of thigh | a. Cold abscess, suspected Pott's disease. | a. Incision and drainage. |
| 8. Muscles and tendons | a. Infected dog bites of tendon of right gastrocnemius muscle. | a. Antirabies serum, Dakin's irrigation to open wound, cast to maintain position. |
| | b. Infected dog bites of Achilles tendon of right foot. | b. Antirabies serum, Dakin's irrigation to wound, sodium bicarbonate tubbings. |
| 9. Veins | a. Phlebitis with edematous congestion of leg and thigh. | a. Elevation of extremity on pillows, continuous light cradle. |
| | b. Varicose ulcer. | b. Unna's boot. |

| Region Involved | Condition Encountered | Treatment [illegible] |
|---|---|---|
| 10. Arteries | a. [illegible] of foot. | a. [illegible] artery [illegible] a wet [illegible], [illegible] infec-[illegible] possible [illegible]. |
| 11. Sciatic sheath | a. [illegible] of [illegible]. | a. [illegible] |
| 12. Foreign body in thigh | a. [illegible] No injury to [illegible]. | a. [illegible] in wound. Bullet left in place. |
| II. *Upper Extremity* | | |
| 1. Hand | a. [illegible] of palm. | a. Removal of needle, suturing of [illegible]. |
| | b. [illegible] | b. Incision and drainage, hot dressings, hot [illegible] soaks. |
| | c. [illegible] | c. X-ray, hot dressings, incision and drainage. |
| | d. [illegible] | d. Operative separation of phalanges. |
| | e. [illegible] | e. Continuous hot wet dressings, [illegible] tions for temperature. Later hot [illegible] soaks to hand. |
| 2. Wrist | a. Colles' fracture of distal end of radius. | a. Plaster cast applied. |
| 3. Forearm, volar surface near middle of [illegible] | a. Contusion with open abrasion. | a. Rest to part, dry dressings. |
| 4. [illegible] | a. [illegible] | a. Venesection, withdrawal of 500 cc. of blood. |
| 5. [illegible] | a. [illegible] | a. Dakin's irrigation. |
| 6. Elbow | a. Abrasion of olecranon [illegible]. | a. Rest to arm. |
| | b. [illegible] | b. [illegible] and further [illegible]. [illegible] |
| 7. Surgical neck of right humerus | a. Fracture. | a. Placed in [illegible]. |
| 8. [illegible] and arm. | a. [illegible] | a. [illegible] |
| | b. [illegible] | b. [illegible] |
| III. *Head and Neck* | | |
| 1. Bones of head | | |
| A. Temporal bone | a. Acute purulent otitis media. | a. [illegible], hot [illegible]. |
| | b. [illegible] with discharge [illegible]. | b. [illegible] |
| B. Frontal bone [illegible] | a. [illegible] | a. Bed rest. |

| Region Involved | Condition Observed | Outstanding Treatment |
|---|---|---|
| | b. Fracture. | b. Suturing of abraded area, treatment for shock. |
| C. Mandible | a. Suspected fracture. | a. X-ray, wiring of bone. |
| D. [illegible] [illegible] maxillary [illegible] | a. Sinusitis as a result of acute coryza. | a. Drainage. |
| 2. Skin and fascia of head and neck | | |
| A. Skin of face | a. First degree burns with bleb formation and infection of eyes. | a. Vaseline and olive oil to skin, boric eye irrigations. |
| B. Eyelids | a. Edema of both eyelids following empyema and myocarditis. | a. Limited fluids, bed rest, systemic medication. |
| C. Dorsal surface left side of neck | a. Cervical abscess. | a. Incision and drainage. Hot dressings. |
| | b. Diabetic cellulitis. | b. Incision and drainage. |
| 3. Tonsillar region | a. Malignant tonsillar hypertrophy. | a. Bed rest, morphine sulphate, p.r.n. |
| 4. Trachea | a. Carcinoma of trachea and lymph glands of neck. | a. Bed rest, morphine sulphate, p.r.n. |
| 5. Thyroid gland | a. Exophthalmic goitre—one month. | a. Thyroidectomy, Lugol's solution. |
| | b. Exophthalmicgoitre—twenty years, with growth beneath clavicle and middle of sternum. | b. Thyroidectomy, Lugol's solution. |
| 6. Brain and appendages | a. Inflammation of gangliated roots of trigeminal nerve. | a. Morphine, ice bag, subsequent surgical procedure. |
| | b. Parkinsonism as sequel to encephalitis. | b. Scopolamin as specific. |
| | c. Meningitis. | c. Isolation, symptomatic treatment. |
| IV. Trunk | | |
| 1. Pelvis | | |
| A. Rectum | a. Tightening of levator ani and external sphincter muscles, due to hemorrhoidectomy. | a. Dilatation of anus. |
| | b. Carcinoma of rectum. | b. Operative procedure, suppositories. |
| B. Reproductive organs | a. Salpingitis, fibroid tumors between rectum and uterus, and between uterus and bladder. | a. Panhysterectomy, excision of fibroid tumors. |
| | b. Vesicovaginal fistula. | b. Operative repair. |
| | c. Bilateral salpingitis with infection of ovaries. | c. Bilateral salpingectomy with oophorectomy. |
| | d. Ectopic pregnancy. | d. Right salpingectomy. |
| C. Bladder | a. Cystitis ([illegible]). | a. Medications. |
| | b. Gunshot wounds puncturing wall in two places, from ventral surface. | b. Insertion of tube for urinary drainage, dressings. |
| 2. Abdomen | | |
| A. Appendix | a. Interval appendicitis. | a. Bed rest, ice bag to side. |
| | b. Appendiceal abscess. | b. Drainage, hot dressings. |
| | c. Ruptured appendix. | c. Emergency appendectomy. |
| | d. Chronic appendicitis. | d. Appendectomy. |
| B. Small intestine | a. Fecal fistula. | a. Drainage. Attempt to close by skin graft and ultraviolet stimulation. |
| | b. Partial intestinal obstruction due to carcinoma of ileum, with [illegible] vomiting of fecal matter. | b. Fluids by mouth and hypodermoclysis. |
| | c. Carcinoma of jejunum. | c. Jejunectomy. |
| | d. Carcinoma of pyloric valve. | d. Gastro-enterostomy. |

| Region Involved | Conditions Observed | Outstanding Treatment |
|---|---|---|
| C. Liver | a. Catarrhal jaundice. | a. Medications. |
| | b. Atrophic cirrhosis of liver. | b. Bed rest, milk diet. |
| | c. Metastasis of carcinoma of the breast to liver with enlargement and nodule formation. | c. Inoperable, bed rest. |
| D. Gall bladder | a. Cholecystitis with cholelithiasis. | a. Cholecystectomy. |
| | b. Rupture of gall bladder. | b. Drainage. |
| E. Pancreas | a. Diabetes mellitus. | a. Insulin, special diet, rest. |
| F. Stomach | a. Carcinoma of lesser curvature, with abnormal peristaltic action, gastric disturbance. | a. Gastro-enterostomy, special postoperative diet. |
| G. Spleen | a. Rupture. | a. Blood transfusion, treat for shock in reverse Fowler's position. |
| H. Kidneys and bladder | a. Chronic nephritis with hypertension, edema. | a. Bed rest, salt-free diet, limited fluids, venesection. |
| | b. Nephrosis with cardiac decompensation. | b. Same as (a). |
| | c. Renal calculus. | c. Bedrest, medications. |
| | d. Pyelitis. | d. Push fluids, bed rest, medications. |
| 3. Abdominal wall | a. Ventral hernia. | a. Herniotomy. |
| | b. Umbilical hernia. | b. Herniotomy. |
| | c. Postoperative hernia of fifteen years' duration following appendectomy, ectopic pregnancy. | c. Herniotomy, salpingectomy. |
| | d. Inguinal hernia. | d. Herniotomy, Dakin's irrigation. |
| | e. Adhesions in umbilical region. | e. Bed rest. |
| | f. Foreign body, three-inch nail, in old abdominal incision. (Patient, [illegible], could not remember placing nail in side.) | f. Excision of foreign body. |
| | g. Tuberculous abscess. | g. Incision and drainage, hot dressings. |
| | h. Abdominal lacerations from knife wounds. | h. Suturing. |
| 4. Thorax | | |
| A. Lungs and pleura | a. Pleurisy with effusion, following pneumonia. | a. Rib resection, removal of fluid from cavity. Dakin's irrigations. |
| | b. Empyema following pneumonia, with [illegible] | b. Drainage, dry dressings, p.r.n. |
| | c. Adhesions. | c. Bed rest. |
| | d. Lung abscess. | d. Medications, serum administration. |
| B. Heart | a. Endocarditis with edema, [illegible] | a. Medications, ice bag. |
| | b. Hypertensive heart disease with [illegible] | b. Absolute rest in bed, medications. |
| | c. Left ventricular hypertrophy. | c. Absolute bed rest, medications. |
| | d. Myocarditis with [illegible] | d. Absolute bed rest, medications. |
| | e. Luetic heart disease with [illegible] | e. Same as above. |
| C. Breast | a. Carcinoma of [illegible] breast with metastasis to liver and progressive jaundice. | a. Bed rest, inoperable. |

| [illegible] Involved | Condition Observed | Outstanding Treatment |
|---|---|---|
| | b. Carcinoma of left breast with involvement of cervical and axillary lymphatics and edema of left arm. | b. Bed rest, vaseline strips and Dakin's dressings to area, inoperable. |
| | c. Carcinoma of breast. | c. Radical breast amputation. |
| | d. Chronic tuberculous mastitis. | d. Incision and drainage, Dakin's irrigation, hot dressings. |
| | e. Breast abscess. | e. Incision and drainage, hot dressings. |
| V. Miscellaneous Systemic | Bacterial | |
| A. Joints | a. Acute rheumatic fever. | a. Absolute bed rest, quiet, medications. |
| B. Neuro-muscular unit | a. Syphilis with resultant locomotor ataxia. | a. Specific treatment, mercurial inunctions, neosalvarsan, potassium iodide. |
| C. Intestine | Parasitic<br>a. Amoebic dysentery. | a. Isolation, specific medication, quinine bisulphate enema, emetine subcutaneously. |
| D. Blood vascular | a. Pernicious anemia. | a. Medication, desiccated mucosa pig's stomach. Vitamin high diet. |
| E. Nerves | a. Arteriosclerotic dementia. | a. Institutional care. |
| | b. Acute arsenical polyneuritis, involvement of peripheral nerves. | b. Medication to rid body of arsenic. |
| | c. Huntington's chorea. | c. Institutional care. |
| | d. Acute alcoholic polyneuritis. | d. Paraldehyde, "D.T." mixture. |
| | e. Tumor at filum terminale, with anaesthesia of portions of gluteal region and loss of bladder and rectal control. | e. Surgical procedure. |

# Bureau of Nursing Service

## District No. 5, California State Nurses' Association

In 1927 we responded to calls amounting to [illegible]. In 1928 we responded to calls amounting to 20,793, in 1929 we responded to calls amounting to 27,783.

[illegible] we have made an effort to study [illegible] of nurses in Los Angeles. (I [illegible] 1927 and 1928, only the cards [illegible] were studied.) A survey [illegible] that in 1927, [illegible] nurses [illegible] days each, on call, or a total of [illegible] days in excess of the need; in [illegible] nurses averaged [illegible] 1/7 days each, [illegible] or a total of [illegible] nursing days in excess of the need. In 1929, [illegible] nurses averaged [illegible] 1/7 days each, on call, or a total of [illegible] days in excess of the need. [illegible] over a period of [illegible] years. Surely we should heed these figures and urge a remedy of this situation. Your office has made every effort to impress the nurses who come to Los Angeles from other schools, with the situation.

In studying the cards, it was revealed that the age of the nurse seemed to have little to do with her ability to satisfactorily respond to a call. This unquestionably rests with the personality and competence of the nurse. The greatest number of days on call by any one member was 246 days in 1929. This member graduated in 1925—refused the following types of illness, tuberculosis, communicable, mental, out of the city; she refused to nurse in two hospitals, and four hospitals refused her permission to nurse in their institutions.—From the Official Bulletin, California State Nurses' Association, District Five.

# Questions

A small group of [illegible] ... Tom, Dick and Harry. [illegible]

[illegible]

A [illegible]

[illegible]

An [illegible] the [illegible] equip- [illegible] nurses' [illegible] radio, [illegible] parties, [illegible]

*The paper "The State in Relation to the British Nurse" raises the question of what is the status of the British registered nurse in this country. Probably no two state boards of [illegible] The New York board [illegible]*

The [illegible] evi- [illegible] edu- [illegible] of her [illegible]

In [illegible] we [illegible] train- [illegible] school [illegible] and [illegible]

[illegible]

# The Open Forum

The editors are not responsible for opinions expressed in this department. Letters should not exceed 500 words; anonymous letters are not considered

## Why I Take the Journal

[illegible] inspirations to my profession [illegible] the experiences and accom- [illegible] others in this great field. To [illegible] hardships and problems of [illegible] who have reached great heights [illegible] courage and hope. A few [illegible] was wondering how I could [illegible] window in a downtown store. [illegible] get a suggestion? This kept [illegible] my mind. That very same [illegible] Journal came and, to my utmost [illegible] a short article on window [illegible] jumped for joy; just what I [illegible] I could use it.

[illegible] field I find many nurses [illegible] lonely. Again I find the [illegible] history; it keeps me in close [illegible] great line of progress. The [illegible] in the different depart- [illegible] I find of great help. Like a [illegible] boy, I grasp my first oppor- [illegible] and compare it with my pre- [illegible]. Work will not become tire- [illegible] will not be blue if we keep up [illegible] things and apply ourselves, [illegible] learning.

[illegible] as I read the article regarding [illegible] her life, her work and her death, [illegible] up from my heart to be a more [illegible] and a truer Christian. And so [illegible] every issue of the *Journal* I [illegible] interesting, something useful [illegible]

G. H.

## [illegible] Richards—A Tribute

[illegible] that I [illegible] which came to me [illegible] of the death [illegible] leadership, [illegible] of the [illegible] I read the [illegible] I had the [illegible] associated with [illegible] her was to love [illegible]

[illegible] inspiration to every [illegible] came in contact, and the [illegible] her presence. I remember so well the day that she received her certificate from the Massachusetts State Board of Registration. We were together in her room and she opened the certificate with a twinkle in her eye as she said, "Linda Richards, R.N. Now does that mean Real Nuisance?" I replied, saying that the State Board should have put B.C. on it also, which would mean Building Contractor, for Miss Richards always seemed to be building training schools for other people to occupy.

Now she is gone, but her work will live. Her entire life was characterized by the highest degree of service for others, and her very presence seemed a benediction. One great interest animated her life—her devotion to her calling. Miss Richards, the woman with the beautiful soul and rare sacrificial spirit, is gone from us to that greater school of learning, but her work will live forever.

REBA G. CAMERON, R.N.

*Manila, P. I.*

## *Problems of Reciprocity*

I AM very anxious to hear from some of the nurses who are graduates of Southern schools of nursing, who have been unable to procure registration in New York State. Is it fair to nurses who have spent three years training and who are required to have a high school education, just because our hospitals are not registered by the Board of Regents of the State of New York? Is it fair to young women entering a nurses' training school in the South, when they are not told that they will not be able to get positions to which they might aspire should they have to make their homes in New York State? Circumstances are not always of our own making. Nurses from England and Canada come to our shore and are registered and get the best positions. But several American-born nurses, if she is not from a New York registered hospital, has to take a back seat. It is not the education or the nursing ability that counts, it is the fact that if you are a New York R.N. that gets you the best position.

I am sorry to say that the state in which I am registered gives reciprocity to New York schools of nursing. We do not come to this

state to take the work from the New York nurses, any more than they come to our state [illegible] they are shown all the courtesy that can be extended to the [illegible].

This letter is not written through malice, but if we are to be considered as only under-graduates, [illegible] I [illegible] feel we should be considered by our country.

A. B.

*New York.*

This writer overlooks [illegible]. The question of citizenship is not the pertinent issue here. The problem is one of [illegible] standards of individual schools and the preparation of individual nurses. Nurses desiring registration in New York, whether graduates of schools in New York state or in other states, must have graduated from schools approved by the New York Board of Regents [illegible] —*Editor.*

## Journals Wanted

ELLEN L. BUELL, Chairman of the Library Committee, Henry Street Visiting Nurse Service, 99 Park Avenue, New York City, will be glad to purchase the following *Journals*: 1926, January, February, March; 1927, October.

M. A. [illegible], Director of the School of Nursing of the Norwalk General Hospital, Norwalk, Conn., would like the following *Journals*: 1900–1907; all of 1908; January, March, June, September, October, November and December, 1919; February, 1922; July, 1924.

## Her Branch of Nursing

I'VE [illegible] branch of nursing. [illegible] After graduating from a school in California I did postgraduate work with the Victorian Order of Nurses in Vancouver, B. C. [illegible] to Alaska under the Bureau of Education in 1916; married in 1919; widowed in 1920. I was appointed [illegible] village nurse [illegible] with a U. S. Dispensary [illegible]. It sounds grand, and I certainly [illegible]. In the mornings, village rounds; in the afternoons, dispensary hours; the evenings, if I choose to [illegible] make my reports. Village visiting includes social service, [illegible] and general [illegible]. By working all the year, I get the [illegible]. This [illegible], mis-[illegible], and [illegible]. I do school nursing in two schools —[illegible] and [illegible] keep records in personal hygiene as well as having weigh days at the dispensary for each school. Then there are follow-up work, emergency calls, and child welfare. By dint of much talk and making [illegible], I have the mothers of the preschool children coming each month for weighing and care. All who lose are given milk and cereal until the weight [illegible] again.

These things I do, except for Sunday [illegible], the year round. Now you tell me what kind of a nurse I am, I don't know, but I do know that I find courage and help in my profession, both the *Journal* and the *Public Health Nurse*. [illegible] help in my school work [illegible] supplied by the Metropolitan Life Insurance Company is a real boon to this isolated, struggling, happy, though sometimes tired, nurse.

*Alaska.* S. A. H.

## An Insurance Policy

RUTH LILLIAN LANE, Springfield, Mass., has a policy and money due her from the Prudential Insurance Company, according to J. J. [illegible].

ALMA H. SCOTT,
*Assistant Director, A. N. A.*

## Teaching under Difficulties

I HAVE just managed to send my file of *Journals* for [illegible] hospital [illegible]. I have [illegible] [illegible]

*India.* [illegible]

# Miscellany

## Jane A. Delano

[illegible], JANE AMINDA (March 12, [illegible] 15, 1919), teacher, nurse, [illegible] New England stock, was born [illegible] N. Y., the second child of [illegible] Mary Ann (Wright) Delano. [illegible] of teaching she entered the [illegible] School of Nursing, New [illegible]. Those associated with [illegible] speak of her as a well [illegible], so unobtrusive in her [illegible], if any, of her classmates did [illegible] the force and char- [illegible] later bring her name and [illegible] before the eyes of the world. [illegible] after her graduation, she was [illegible] of nurses at a hospital in [illegible], during an epidemic of [illegible]. The following year she gave [illegible] as a visiting nurse in a mining [illegible] Ariz. After a period of pri- [illegible] she was appointed superinten- [illegible] at the University of Pennsyl- [illegible] School of Nursing, serving [illegible]. In 1900 she took a course at the [illegible] School of Civics and Philanthropy. [illegible] of the Girls' Department, [illegible], Randall's Island, New York, [illegible] and from May, 1902, to October, [illegible] of the School of Nursing at [illegible]

[illegible] Spanish-American War she had [illegible] York Branch of the American [illegible] [illegible]

AMERICAN JOURNAL OF NURSING, and from 1909 to 1912 she was president of the American Nurses' Association.

She resigned from the Army Nurse Corps in 1911 to devote her entire time to Red Cross organization. A Bureau of Nursing Service was created in 1916 under which was placed the selection and assignment of nurses and organization of all military and other nursing units. A Department of Nursing was created in 1918 with Miss Delano as director. When the Armistice was signed the Red Cross Nursing Service had assigned 17,931 nurses to the Army; 1,058 to the Navy; 284 to the United States Public Health Service, while 604 were working under the Red Cross with the civilian population in the countries of the Allies. The Nursing Service also supplied 553 Red Cross aides for special work in France, and to the influenza epidemic in 1918, especially to war industries, over 15,000 graduate and practical nurses and volunteer aides.

The war over and the influenza epidemic allayed, Miss Delano sailed on January 2, 1919, for France, on her last tour of inspection. Developing a mastoid, from which she never recovered, she died at Savenay Hospital Center, April 15, 1919. It was characteristic of her devotion to the Red Cross that her last words were, "What about my work? I must get back to my work." It was also characteristic of her that, as a memorial to her mother and father, she should leave a legacy, together with the royalties from the *American Red Cross Textbook on Elementary Hygiene and Home Care of the Sick* (1913), which with Isabel McIsaac she found time to prepare during her busy Red Cross days, and to support one or more visiting nurses in communities where none existed. Many decorations were bestowed upon her by foreign countries; the Distinguished Service Medal of the United States and that of the American Red Cross were posthumously awarded.

From the 5th volume of the *Dictionary of American Biography*. Charles Scribner's Sons, New York.

# Abstracts

**Diagnosis of Pregnancy:** [illegible]

[illegible]

The [illegible] the [illegible] positive [illegible] biologic [illegible] Therefore, [illegible] positive [illegible] or not [illegible] death. [illegible] diag- [illegible] of [illegible] over. [illegible] [illegible] opera- [illegible]

**[illegible]: P. A. O'Leary, M.D.** (The *[illegible] of the Mayo Clinic,* April 30, [illegible])

*Summary.* Of the [illegible] patients [illegible]

[illegible]

# News

[illegible] items should be typed, if possible, double space, or written plainly, especially proper names. All items should be sent before the 15th of the month preceding publication.

## The American Nurses' Association

[illegible] actions were taken at the House of [illegible] of the American Nurses' Association [illegible] in convention in Milwaukee. [illegible] interest, perhaps, were those [illegible] the Relief Fund. The advisability [illegible] relief-giving on a national [illegible] discussed, it will be remem[illegible] several years, those who have [illegible] having recommended [illegible] of the national fund for [illegible] (1) because the demands on the [illegible] were steadily exceeding the in[illegible] (2) because it is felt that relief [illegible] national basis is unwisely unsound. [illegible] actions on the part of the [illegible] are, therefore, of interest [illegible]

[illegible] House of Delegates adopted the [illegible] Relief Fund Committee, [illegible] had been recommended by [illegible] of the A. N. A., and [illegible]

[illegible] Convention."

The House of Delegates then adopted the recommendation made by the Relief Fund Committee in the event that the delegates should vote to adopt the above resolution. These actions were taken only after considerable discussion had taken place on the part of various delegates, representing diverse opinions with regard to the Relief Fund. This second recommendation to be adopted was as follows:

"*Moved* by Miss Nelson, seconded by Miss Francis and *carried* that if it is voted to discontinue the Fund, the Relief Fund Committee recommends that the Committee be empowered to expend sufficient money from the Fund itself to study our situation in order to formulate some plan for meeting our already assumed obligations; to assist in making some constructive plan for the states desiring to continue relief projects, and to get assistance and advice in helping the Committee to prepare their final recommendations for the disbursement of the Fund itself."

### Actions Concerning Dues

That most perplexing problem of dues was thoroughly discussed and actions were taken by the House of Delegates which promise to simplify the system whereby the dues of the individual member or of alumnae members find their way to the National Office. These are the actions taken in Milwaukee.

#### *Dues*

These changes were voted by the House of Delegates at the Biennial Convention, and were deemed necessary in order to provide for the collection and payment of dues during the same calendar year for which the dues entitle the nurse to American Nurses' Association membership.

*Article VIII*, as revised, now reads:

*Section 1.* The annual dues from each state association shall be fifty cents per capita.

*Section 2. Dues shall be paid in advance, not later than March 15, for the current calendar year, on the basis of membership, January 31.*

*Section 3. State associations whose dues*

*have not been paid by April 15 shall be notified by the treasurer, and those not paying by May 15 shall forfeit membership.*

Section 4. State associations having forfeited their membership may be reinstated upon the payment of dues for the fiscal year.

Section 5. *Dues received by state associations after March 15 shall be paid monthly during each year.*

Article XV, Section 4, as revised, now reads:

To send to National Headquarters a classified typewritten list of all members with dues as provided in Article VIII.

This revision calls for some uniform plan for collecting dues from the alumnae associations and individual members of a district association to the district association treasurer (where the state is districted), from the district association to the state association, and from the state association to the American Nurses' Association, if uniformity among the state nurses' associations and transfer from one state association to another state association are to be effective.

The following plan for the collection of dues within the several state associations is, therefore, respectfully submitted:

DURING JANUARY of each year—
1. Collect alumnae-association dues;
2. Collect individual dues;

BY FEBRUARY 15 of each year—
Send alumnae dues to district treasurer;

BY MARCH 1 of each year—
Send district dues for both alumnae and individual members to the state treasurer;

BY MARCH 15 of each year—
Send state dues to headquarters of the American Nurses' Association.

Please note:

I. *Dues collected during the year 1930.* Dues collected during the year 1930 as dues for American Nurses' Association membership for 1930, whether for reinstatement or for new members, are to be forwarded to National Headquarters not later than January 1, 1931.

II. *Dues collected during the year 1931 and up to March 15, 1931.* Dues received during the year 1931 and up to March 15, 1931, as dues for American Nurses' Association membership for 1931, are to be forwarded to National Headquarters not later than March 15, 1931, as provided in the revised Article VIII, Section 3, of the By-Laws of the American Nurses' Association, above stated.

III. *Dues collected after March 15, 1931.* Dues received by state associations during the year 1931, after March 15, 1931, as dues for American Nurses' Association membership for 1931, are to be paid monthly to the American Nurses' Association during 1931.

RESOLUTIONS

The past of nursing and the present of nursing were linked closely at the convention when the A. N. A. Resolutions Committee paid formal tribute to those great nurses who had died during the biennial period.

Among these resolutions was one carrying appreciation of the loss suffered by the American Nurses' Association in the death of its President, S. Lillian Clayton. It was resolved that the convention [illegible] as desiring to express its appreciation of her leadership, her sincerity, her sympathetic understanding, kindness and justice, and of her unremitting labors and untiring zeal for the good of humanity.

Another resolution commemorated Linda Ann Judson Richards, known as America's first trained nurse, who in 1873 was graduated from the New England Hospital for Women and Children, and who passed on at that hospital April 16, 1930. It was the desire of the Committee that the members of the A. N. A. acknowledge their indebtedness to the high qualities of leadership expressed in her professional life through the establishment of nursing service in hospitals in this country, especially those for the mentally ill, and in hospitals in Japan as well.

It was further resolved that the members express their appreciation of the contribution of Jane A. Delano, [illegible]

[illegible]

[illegible] their courtesy and kindness; [illegible] generous interest and cooperation [illegible] the exhibitors for their cooperation [illegible] the educational value of their [illegible]

[illegible] resolved, in recognition of [illegible] unexpected responsibility [illegible] the direction of the Field [illegible] E. Thomas, that the [illegible] appreciation and gratitude [illegible] courage and graciousness with [illegible] carried on the affairs of the Association.

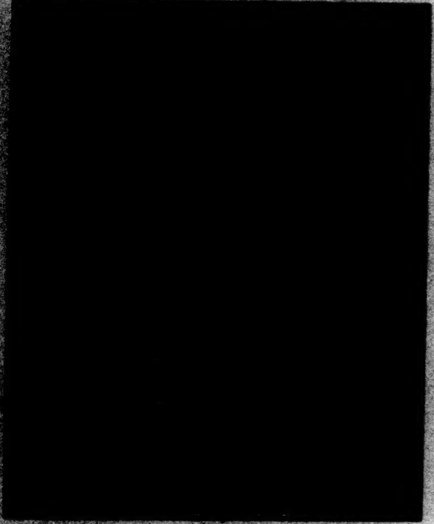
### Addition to Staff

On [illegible] 1, Ella Best will become Field Secretary of the American Nurses' Association [illegible] which she promises much [illegible] Miss Best is a graduate of [illegible] Luke's Hospital School of Nursing [illegible]

[illegible] period of private duty, she [illegible] instructor in Nursing in [illegible] Following postgraduate [illegible] College, New York, she [illegible] Valley [illegible] this with [illegible] Michael Reese, [illegible] another year [illegible]

[illegible] Best has been assistant to [illegible] the school in Cook County [illegible] A thorough student, Miss [illegible] summer session at the University [illegible] and has been a part-time [illegible] University of Chicago Medical [illegible]

[illegible]



Ella Best, R.N.

## *Nurses' Relief Fund*

**Report for Month Ending June 30, 1930**

*Receipts*

| | |
|---|---|
| Interest received on investments | $915.36 |
| Interest received on bank balances | 14.27 |

*Contributions*

| | |
|---|---|
| Arkansas: District 4, B, $24; Leo N. Levi Alumnae Assn., $20 | 44.00 |
| California: State Nurses' Assn. | 244.50 |
| Iowa: District 2, $69; District 3, $109 | 178.00 |
| Kansas: State Nurses' Assn. | 4.00 |
| Kentucky: Norton Infirmary Alumnae Assn. | 25.00 |
| Michigan: State Nurses' Assn. | 1,000.00 |
| Mississippi: Individual contributions | 5.00 |
| New Hampshire: Alumnae associations—[illegible] | 55.00 |
| New Jersey: District 1, alumnae associations—[illegible] | 273.00 |
| Texas: District 1, [illegible]; District 4, [illegible]; District [illegible]; District 15, [illegible] | 79.00 |
| Washington: [illegible]; Tacoma, $15; [illegible]; Walla Walla, [illegible]; [illegible], $15 | 79.00 |
| | $1,985.50 |
| Total receipts | $2,915.06 |

Disbursements

| | |
|---|---|
| [illegible] | [illegible] |
| [illegible] | [illegible] |
| Total disbursements | [illegible] |

[illegible] June 30, 1920 [illegible]

All contributions to the [illegible] Relief Fund [illegible] [illegible] New York City.

## National Association of Colored Graduate Nurses

The National Association of Colored Graduate Nurses will hold its next annual meeting in Memphis, Tenn., August 12 to 15 inclusive. A large attendance is expected.

## Army Nurse Corps

During the month of June, 1920, orders were issued for the transfer of members of the Army Nurse Corps to the stations indicated: To Fort [illegible], [illegible] 2nd Lieut. [illegible]; to Fort [illegible], Okla., 2nd Lieut. [illegible] A. [illegible]; to Fort Totten, N. Y., 2nd Lieut. [illegible]; to West Point, N. Y., 2nd Lieut. Florence [illegible]; to Philippine Islands, 2nd Lieut. [illegible].

Seven [illegible] to the Corps as Second Lieutenants. [illegible] Headquarters [illegible].

The following [illegible]: Sara H. [illegible], [illegible] G. [illegible], [illegible] C. [illegible], Lela B. [illegible], [illegible] Noble L. [illegible], [illegible] H. Thomas, [illegible] Olson.

Julia C. Stimson,
*Major, Army Nurse Corps,*
*Superintendent.*

## Navy Nurse Corps

Report for June, 1920

Appointments: Ten.

*Transfers:* To Cavite, P. I., [illegible] Brooks, Florence A. [illegible]; to Chelsea, Mass., [illegible] L. [illegible], Muriel H. [illegible], Marjorie E. Wheeler; to Guam, [illegible] Hassler, Gertrude [illegible]; to League Island, Pa., Janet C. [illegible]; to Mare Island, Calif., Mary J. [illegible], Mary [illegible], [illegible] Cleaver, [illegible] G. [illegible], [illegible]; to New York, Gertrude M. [illegible], Mary M. [illegible], [illegible] M. [illegible]; to Norfolk, Va., [illegible] Marsh, [illegible] Taylor, [illegible] G. Wright, Ethel J. McCormack; to Philadelphia, Pa., University of Pennsylvania, instruction in anaesthesia, [illegible]; to Puget Sound, Wash., Helen [illegible], [illegible] Elizabeth O. [illegible]; to U. S. S. Relief, Helen I. White; to St. Thomas, V. I., [illegible] V. [illegible]; to Washington, D. C., Cornelia A. Armstrong, Lucy H. [illegible].

J. Beatrice Bowman, R.N.,
*Supt., Nurse Corps, U. S. Navy.*

Helen M. [illegible], nurse, U. S. Navy, received one of the pens used by the President of the United States, on June [illegible], 1920, in signing the Act of Congress giving Army and Navy nurses retirement for disability in line of duty. The pen was accompanied by the following letter from the Superintendent of the Navy Nurse Corps:

"While it is recognized and appreciated that all members of the Nurse Corps were [illegible] in [illegible] the [illegible], yet [illegible] position [illegible] could [illegible] with [illegible] Corps and [illegible] you are [illegible] of your [illegible] to the [illegible]."

## U. S. Public Health Service

The following [illegible] the U. S. Public Health Service during the month of [illegible].

[illegible]

[illegible] to Fort Stanton, N. M., [illegible] to Evansville, Ind., Joseph [illegible], Ky., Nora W. Turville, [illegible] St., New York City, [illegible] Acting Chief Nurse. [illegible] No reinstatements during [illegible].

[illegible]: Mary Louise Huber, [illegible] Shock, Anna Shoe-[illegible], Edna Evans, Flossie [illegible] McHugh, Beatrice Wofford, [illegible], Mabel Neikirk, Ethel [illegible], Naomi Moore, Mary E. Wood, Olive Neal.

LUCY MINNIGERODE,
*Supt. of Nurses, U. S. P. H. S.*

## *United States Veterans' Bureau*

REPORT OF NURSING SERVICE, JUNE, 1930

The [illegible] hospital construction pro-[illegible] of the Veterans' Bureau is being com-[illegible] speed. The sites of the [illegible] are being located as near as [illegible] center of the disabled mili-[illegible], taking into consideration [illegible], water and other neces-[illegible]. Generally speaking, it may [illegible] the largest hospital load [illegible] in the vicinity of the large [illegible] is particularly so with the [illegible] load.

[illegible] may be had of the problems which [illegible] when one realizes that [illegible] that the hospitalization [illegible] connected cases is equiva-[illegible] 250-bed hospitals, [illegible] growing from year to year. [illegible] at the Veterans' [illegible] at North Chicago, [illegible], it is expected will be [illegible] of patients about [illegible] provide 300 additional [illegible] other facilities. This [illegible] and [illegible] of [illegible]. It will be seen [illegible] and future prospects for [illegible]

[illegible]

During the month of June the following-named nurses have been reinstated: Mary Scarborough, Harriet K. Luther, Florence Kerr Caushy, Zilla M. Clark, Lillian Hill.

*Assignments:* Nineteen.

The following have been separated from the service: Serine Aarestad, Elinor A. Brinson, Lillian Bowie, Anna L. Caldwell, Edna C. Cannon, Josephine Cleif, Emilie B. Eggens, Hannah J. Flahive, Mame P. Freeman, Anna H. Gjovre, Emma J. Hall, Lucile Hardy, Kathryn Hussey, Ines Hurte, Lula M. Johnson, Velma Helmberg, Florence Kyle, Rose A. Leddy, Mary C. Lindsey, Mary V. Mahany, Laura E. McKinnon, Alice M. Morrissey, Vivianne R. Patrick, Clara L. Parker, Josephine Phelps, Flora E. Ritchie, Margaret M. Roach, Valborg C. Simonsen, Katherine Tilton, Louise A. Wade, Mary Maroney.

*Transfers:* To Minneapolis, Minn., Alice Ryberg.

MARY A. HICKEY,
*Supt. Nurses, U. S. V. B.*

## *U. S. Indian Service*

During the month of June, the following changes took place in the nursing personnel of the Indian Service:

*Appointments:* Two.

*Separations:* Four.

*Transfers:* To Cherokee School, North Carolina, Edith L. Alexander.

ELINOR D. GREGG,
*Supervisor of Nurses.*

## *Hospital Standardization Conference*

The thirteenth annual meeting of the Hospital Standardization Conference of the American College of Surgeons will be held at the Bellevue-Stratford Hotel, Philadelphia, the week of October 13, the same week as the Clinical Congress.

The program will deal with ways and means of improving all phases of hospital administration, more particularly as related to the scientific and efficient care of the patient. It will consist of addresses, papers, round table conferences and general discussions. These will embrace such practical topics as the following: "What the Hospital Standardization Movement Means to the Present-Day Practice of Medicine"; "What is the Ideal Hospital?"; "Problems of the Rural Surgeon and

[illegible]

## The American Dietetic Association

The American Dietetic Association will hold its [illegible] annual convention, in Toronto, Ontario, Canada, September [illegible], 9, and 10.

## State Boards of Examiners

[illegible]

[illegible] Atlanta, [illegible] provided [illegible] received. [illegible], 131 [illegible]

## State Associations

[illegible] of the [illegible] Con- [illegible] October [illegible]

[illegible] As- [illegible] No- [illegible] Kathe- [illegible] Hospital, [illegible] Pro- [illegible]

[illegible] As- [illegible] at the [illegible] Baden [illegible] re- [illegible] Journal for [illegible]

[illegible] Kentucky [illegible] President, [illegible] Lou [illegible]

[illegible]

[illegible] and Marion Vannier. Miss [illegible] Superintendent of Hillcrest [illegible] years, and active in [illegible] work, serving on many com- [illegible] President of the Minnesota [illegible] 1931-32. Miss Van- [illegible] the University School, first [illegible] assistant to Louise Powell, [illegible] Powell's retirement, Director [illegible] has always been interested [illegible] and in the institutes [illegible] of the summer [illegible] and administration, and [illegible] all movements for the inter- [illegible] of nursing education and [illegible] will live in California. Both [illegible] Miss Vannier were guests of [illegible] League at the meeting in May, [illegible] at a tea in June. There [illegible] the Minnesota Register at [illegible] attended the Minnesota [illegible] Hotel on Wednesday [illegible] of the after-dinner pro- [illegible] What and Who's Who," [illegible] provided as each one pres- [illegible] is, what she does, and what [illegible] Mary E. Gladwin and Mary [illegible] introduced as guests. Miss [illegible] gave short talks.

[illegible] The twenty-third annual meeting of [illegible] State Graduate Nurses' [illegible]

was shown in Oregon, as sixteen nurses attended, while the membership entitled the state to only ten delegates.

Following the business meeting, Mrs. Saidie Orr Dunbar, Executive-Secretary of the Oregon Tuberculosis Association, gave a very comprehensive report of the White House Child Health Conference. Jennie Hunter, Physiotherapist, Shriners' Hospital for Crippled Children, gave a lecture and demonstration with patients on "Physiotherapy" with particular attention to the care of post-acute poliomyelitis. Dr. Ralph C. Matson, President of the American Sanatorium Association, gave an address on "Newer Surgery and Anaesthesia in Tuberculosis," illustrated by slides. Daisy Dean Urch, President of the California State Nurses' Association, brought the meeting to a close with an address on "Higher Education for Nurses." Following the conclusion of the social sessions, the report of the tellers was read, which showed the following officers and Board of Directors members to be elected: President, Jane D. Gavin; vice presidents, Helen McCusker, Freda Folkman; secretary, Mrs. Louise H. Cliff; treasurer, Violet Kirschner; directors for three years, Cecil Schreyer, Beth Freeman, Hope Brady.

South Dakota: The South Dakota State Association held its annual meeting in Rapid City, July 29–30, too late for a report in this *Journal*. A report will appear in the September number.

Wisconsin: The newly elected officers of the Wisconsin League of Nursing Education are: President, Ethel Odegard, Milwaukee; secretary, Ida C. Baer, Milwaukee.

## *District and Alumnae News*

Connecticut: Hartford.—Sister Catherine [illegible] and Sister Alice Mary Leary, graduates of St. Francis Hospital School of Nursing, have returned to take charge of the [illegible] department and serve as instructors, after completing a course at the Pratt Institute, Brooklyn.

[illegible]: Chicago.—The third regular meeting of the First District was held at the Chicago Woman's Club, June 17, [illegible] presiding. Reports of the Biennial Convention were presented by [illegible], Mrs. [illegible], and [illegible]. As part of her report Miss [illegible] read the paper which she had given at the convention on "Hospital Relationships

[illegible]

[illegible] 12, at the hospital. The address was [illegible] Hugo Hirsh. Clifton Springs. [illegible] meeting of the LEAGUE OF [illegible] was held at the Clifton [illegible] on June 17, and was a [illegible] of the convention in Milwaukee, [illegible] by a picnic. Arrangements for a [illegible] the University of Rochester for [illegible] and head nurses in "Methods of [illegible]" has been completed. The course [illegible] a period of fifteen weeks and will [illegible]. Laura McGregor of the [illegible] of Education of the city is to [illegible]. New York.—The Katherine [illegible] Scholarship was founded this [illegible] ALUMNAE ASSOCIATION OF THE [illegible] HOSPITAL SCHOOL OF NURSING [illegible] to Miss Sanborn, the Director [illegible] for thirty-eight years. The [illegible] provides an annual purse of $600 [illegible] awarded yearly to a member of [illegible] Association who is desirous of [illegible] her nursing education. Troy. —[illegible] HOSPITAL held commence[illegible] for a class of nineteen at [illegible] Hotel, June 20. The address was given by Nina D. Gage.

North Carolina: District 1, Asheville.—The [illegible] meeting was held June 11, [illegible] president, Jane Brown, presiding. The June *Bulletin* from National Headquarters was read, and the article on "Hourly [illegible]" was discussed with interest. Lockie [illegible] of Greensboro, Acting Secretary of the State Association, was present and made a short address. A committee, with Mary [illegible], Chairman, was appointed to serve [illegible] in making a study of the [illegible] and by-laws. The [illegible] HOSPITAL ALUMNAE ASSOCIATION held the annual meeting at the Nurses' [illegible] on June [illegible]. The following officers were [illegible]: President, Myrtle [illegible]; vice [illegible]. The [illegible] HOSPITAL [illegible] ASSOCIATION held the regular meeting on June 4, at the Nurses' Club. [illegible] paper on "Linda [illegible]" was read by Mrs. Charles Jenkins. [illegible]

District 3, Winston-Salem.—The regular meeting on June 26 was held with good attendance. A most interesting report of the Biennial Convention was given by Mary Oliver. District 5, Durham.—After the usual business session, R. B. Reese spoke, at the regular District meeting in June, on the "Value of Life Insurance for Nurses." A memorial service was held in honor of S. Lillian Clayton, late President of the American Nurses' Association, and Linda Richards, America's first graduate nurse. District 9, Wilmington.—The regular meeting in June was in charge of the vice president, Mrs. A. J. Peiffer. Tributes to the life and memory of S. Lillian Clayton were read by Columbia Munds. The June *Bulletin* from National Headquarters was read with interest. Janet Geister's letter, following the Institute for Executive Secretaries, held in New York in March, was re-read and discussed. A resolution was adopted that the District appropriate funds for the maintenance of North Carolina State Headquarters for one month as its contribution to the work for the coming year.

Ohio: Canton.—DISTRICT 1 held its regular meeting at Meyers Lake Park, July 15, with the program in charge of the Educational Section. Findlay.—DISTRICT 13 held its regular meeting at Findlay Country Club, July 23. Dr. Hartman of Findlay gave a talk and Mary L. Margerum gave a report of the Biennial Convention.

Pennsylvania: Ashland.—The meeting of DISTRICT 2 was held at the Nurses' Home, Ashland State Hospital, with a large attendance. Following the business session, K. Frances Cleave, Nursing Consultant of the State, gave a very interesting talk on "The Functions of the Welfare Department." A demonstration of "Isolation Technic" was given by a senior student. Inspection was made of the new nurses' home and a tour of the hospital followed. Braddock.—BRADDOCK GENERAL HOSPITAL ALUMNAE ASSOCIATION held its regular meeting, June 9, in the Nurses' Home. Plans were made for a theatre party to be held in October, the proceeds to go to the Hospital Building Fund. Philadelphia.—Loretta M. Johnson, Philadelphia General Hospital School of Nursing, [illegible], has been appointed Superintendent of Nurses at the Philadelphia General Hospital. Following her graduation Miss Johnson was assistant instructor, then instructor in Practical Procedures. She then became a supervisor. Miss Johnson has been also Superintendent of Nurses in a small hospital and

# About Books

[illegible] AND SYPHILOLOGY FOR [illegible]. By John H. Stokes, M.D. [illegible]. 69 illustrations. W. B. [illegible] Company, Philadelphia. [illegible]. Price, $2.50.

I[illegible] past, with few exceptions, [illegible] a medical man prepared a [illegible] for nurses he simply gathered [illegible] a few medical oddments, [illegible] sentence on don'ts [illegible] nurse and christened the result "[illegible] for Nurses." Consequently, it is refreshing to read Dr. [illegible] *Dermatology and Syphilology for Nurses*, for here an entirely new policy has been inaugurated; from cover to cover it is written for the nurse. It is distinctly not a compilation of [illegible], not a résumé of former [illegible], but a book written primarily for nurses by a leader in the field of dermatology and syphilology.

The book differs from other similar works in so many respects that it might be termed revolutionary, for the approach is from an entirely new angle. All undesirable terminology has been omitted, and simple, understandable language is the rule. There are no lengthy discussions on moot [illegible] etiology, but established [illegible] and forcibly stated in [illegible] language. There is no [illegible] the reader with doubtful [illegible] but important [illegible] are set forth to clearly [illegible]

[illegible] is a [illegible] and [illegible] at the end of each chapter, [illegible] still more forcibly to the attention of the nurse important factors in the management of nursing care. True, many of these "thumbnail sketches," as Dr. Stokes so aptly calls them, are titled "Treatment for . . . ," but they deal solely with the manner in which the instructions of the physician are to be carried out and allow the nurse no leeway in the matter of prescribing or suggesting treatment. The author is especially insistent that the nurse realise her part in the play. She is not to devise treatment, but to carry out instructions, and it is his explicit teachings in this respect that makes the book so valuable.

Not alone is Dr. Stokes emphatic in his teachings of *what to do*, but he is equally emphatic in his admonitions of *what not to do*, as, for example, the chapter dealing with the preparation of a patient for x-ray therapy. The injunction to remember that you are dealing with the "Dangerous Unseen" should be emblazoned on the walls of every x-ray laboratory. On page 130, Fig. 27, there is a summary, for the nurse administering x-ray treatment, consisting of twenty rules, which is unequaled for brevity and yet is so clear and comprehensive that no nurse could possibly err in the application of this treatment. Of equal moment are the instructions to patient taking x-ray treatment.

Chapter XX, "Diagnosis and Diagnostic Tests in Syphilis: Darkfield, Blood, and Spinal Fluid," written in simple understandable English, clarifies the technic and the like of the

various serologic tests which are so confusing to most minds.

The book is not overcrowded with illustrations, but a number of clear plates add to its value.

It would be unfair to this really great little book to omit a word of praise of Part IV, which deals with the principles of social hygiene. This is really a heart-to-heart talk with nurses by a man thoroughly versed in every phase of this enormous problem of social medicine—a foremost medical man, a master in both the art and science of his profession. Beginning with "Social Hygiene and the Nurse," passing to the "Social and Economic Background of Syphilis and Gonorrhea," then to "The Organized Venereal Disease Control and Social Hygiene Movements," and terminating with a truly beautiful viewpoint on "Normal Ideals of Sex Life," it gives the reader not alone valuable instruction, but genuine pleasure. No one can fail to be impressed with the lofty ideals and the sincerity of the author.

The style of writing makes delightful reading. The beauty of the language may be appreciated from the following quotation taken from Chapter XIX, "The History, Cause and Prevalence of Syphilis":

> There is not an aspect of the whole field of medicine and surgery and all the specialties into which it does not thrust itself. Its history contains the essential elements of the dramatic. According to the most widely accepted view, it sprang from ambush, so to speak—a direct importation by the sailors of Columbus, from the island of Haiti. It has swept the world in devastating epidemics, and defeated vast armies more effectively than pike, powder and shot. It has been immortalized in poetry, has held the stage at the center of medical discussion, and its treatment furnished the first and most memorable of the triumphs of chemical science over disease. And more intriguing than all that, for the average man, is its Machiavellian cunning. Insanity, death, hover in its wings and strike from the clear sky among our friends and hobnobs impartially with the great ones of the earth. Three children in a hundred, and from five to ten adults have the disease. In hospitals as high as twenty patients in a hundred have the disease. It has been believed to be incurable. Through the comparatively short cycle of centuries in which it has been at work it has, through its inherited form, modified the entire destiny of mankind, and left its stamp upon the race. No pathologic area is so pure that syphilis has not twined itself among its branches. Small wonder, then, that it is easy to write about syphilis, easy to study it and easy to hold audiences with its story.

There is no other textbook for the nurse which so faithfully, so graphically, and so beautifully describes the tragedy of syphilis.

ANN DOYLE, R.N.

*New York*

HOSPITAL ECONOMICS FOR NURSES. By Phoebe Miller Kandel, R.N. 276 pages. Harper and Brothers, New York. 1930. Price, $5.

THE advent of this volume on the subject of hospital housekeeping will be hailed with delight by both educators and administrators, since it aids much in their mutual problems. The opening chapters serve as excellent orientation material to the mind of the young student. They give a very readable, broad concept of the ramification of interests involved in hospital construction, thereby developing an appreciative attitude on the part of the student through rational, rather than emotional, approach. From this point, it is but logical that the author next develops the need of close cooperation and complete understanding between the nursing personnel and administrative departments. Only in this manner is a sound economic basis of operation and maintenance secured. Further interest and intelligent evaluation of hospital

[illegible] is developed for the student, by a careful explanation of sources of raw materials and different types of construction with the reason given which prompted their variation [illegible] in itself, ought to go far to [illegible] thoughtless criticism and [illegible]appropriation of materials by staff members; it ought to go far to [illegible] more alert and resourceful in the use of that equipment, as well as appreciative of the many persons and the painstaking work involved in its production.

From the general background of the hospital, the book follows the natural order in the experience of the student by discussing the planning, construction, equipment, staff, and general care of the nurses' residence. With this information the reader is well prepared for the more detailed chapters which follow, on ward equipment; cleaning of wards and cleaning of equipment; replacement of supplies; care of linens; supply and disposal of foods and waste; discussion of the part played by the hospital pharmacy; and last, but of great importance, the removal of stains and control of insects and rodents. In these pages are included price lists which ought to aid greatly in destroying the tendency of many students to take for granted the unending source of supplies furnished for their use. The purchase price of linens, dishes, mattresses, etc., is far too often a matter of no consideration to the nurse because that fact has never been placed before her. Carefully made "process charts" call attention to the [illegible] of con[illegible] and work necessary to [illegible] and clean equipment.

The final chapter and appendix on [illegible] Management would be of more value to the head nurse, supervisor, and nursing administrator than to the student, for its principles are rather beyond her scope. To those of higher responsibilities the author gives many helpful suggestions in her lists of duties and schedules for ward maids, orderlies, and porters. The approximate costs of certain drugs, enamelware, rubber goods, cotton, etc., ought to serve as splendid teaching material for the ingenious head nurse who wishes to aid her staff in developing a sense of economic use of ward supplies.

Valuable review questions are listed at the end of each chapter as well as collateral bibliography. Throughout the book one has the persistent feeling that the author has left no stone unturned by which she might make sure of her statements before their publication. Many experiments have been performed for collecting her data; careful, detailed research has ferreted out facts on which she has based her discussion. Whether for text or reference use we have reason to be truly grateful for this addition to our professional library.

Dorothy Rogers, R.N.

*Missouri*

Ethics. Talks to Nurses. By Mary E. Gladwin, R.N. 281 pages. W. B. Saunders Company, Philadelphia. 1930. Price, $2.

UPON a background of wide and appreciative reading and long experience in nursing of many kinds in many places, Miss Gladwin projects, in limpid prose, a few of the eternal verities of ethics. "Few of us sit down to face the personal problem of how to use and make the most of our lives, and most of us lack an incentive powerful enough to override our inertia and compel us to effort," says Miss Gladwin.

The book should be a friendly guide in overcoming such inertia. It is not a treatise in ethics, it makes no pretense at comprehensiveness. It is a

series of friendly talks on a few of the more common problems which confront students and graduate nurses. The approach is forthright. In the chapter, "The Tone of a School," we find:

The [illegible] [illegible] [illegible] [illegible] [illegible]

Summing up the chapter on "Ethics and Duty" she says, "Ethics is quite distinct from religion, but the noblest concept of the life governed by ethical principles is that which accepts St. Paul's beautiful description of charity beginning, 'Charity suffereth long and is kind.'"

The chapters "The Patient and the Nurse," "Gossip," "Truth," "Discipline," "Punctiliousness," "The Opposite Sex," "Good Manners," "Fees and Gifts" contain practical discussions of all-too-common problems. The chapters "Vocabulary and Books," "Success," and the lovely concluding chapter on "Our Exemplar" (Miss Nightingale) should have wide reading.

The book will be warmly welcomed by teachers of ethics. It might be made more convenient for such use by placing the thought-provoking questions, which are now [illegible] in the text, at the end of the chapters. It has real value for graduate nurses and some of the chapters, such as "Fees and Gifts" and "[illegible]," might profitably be used for alumnae programs.

M. M. R.

*New York*

**Practical Planning for Hospital Food Service.** The John Van Range Co., Cincinnati. 1930. Copy sent on request.

While this exceedingly well illustrated pamphlet is frankly gotten up for advertising purposes, it contains much valuable information for those who are confronted with the problems of planning for hospital food service. The plans of many recently built hospitals are included to illustrate different types of food service. The advantages and disadvantages of the two methods of food service are considered—as are space requirements and the factors influencing it, such as the method of serving, the addition of new departments, [illegible] of the special [illegible], and the like. An analysis of food service space in twenty-three hospitals is presented in tabular form. There is also a table showing the [illegible] which must be considered in hospital food service planning. [illegible] Copies of the pamphlet may be had by writing to the John Van Range Co., [illegible], Cincinnati, Ohio.

H. W. M., R.N.

*New York*

### *Books Received*

[illegible]

# Official Directory

[illegible] Council of Nurses.—Sec., [illegible], 14 Quai des Eaux Vives, [illegible]

[illegible] of Nursing Company. [illegible] Ave., New York.—[illegible], Milwaukee Chil[illegible] Wis. Sec., Stella [illegible] Hospital, Boston. [illegible] care American [illegible] New York, N. Y. [illegible] Sally Johnson, Boston; [illegible] St. Louis; Elizabeth [illegible] D. C.

[illegible] Grading of Nursing [illegible] May Ayres Burgess, [illegible] Ave., New York.

[illegible] Association.—Head[illegible] Ave., New York. Pres., [illegible] Portland, [illegible] C. [illegible], Children's [illegible] Pa. Treas., [illegible] Hospital for Women [illegible] Boston 15, Mass. [illegible] M. [illegible], 370 [illegible] New York. Sections: Private [illegible]

[illegible]

Association.—Pres., Edith Soule, State Dept. of Health, Augusta, Maine. Sec., Elizabeth Van Patten, 35 Elm St., New Haven, Conn.

Middle Atlantic Division.—Pres., Jane E. Nash, Church Home and Infirmary, Baltimore, Md. Sec., Marion Durell, City Hosp., New York.

Mid-West Division.—Pres., Mabel Dunlap, Moline, Ill. Sec., Grace Ross, 1415 St. Antoine St., Detroit, Mich.

Northwestern Division.—Pres., Mrs. Elizabeth Soule, University of Washington, Seattle, Wash. Sec., Katherine Leahy, University of Washington, Seattle, Wash.

Southern Division.—Pres., Annie M. Beddow, Norwood Hosp., Birmingham, Ala. Sec., Bernadine Bryant, 903 First Ave., Selma, Ala.

Nursing Service, American Red Cross.—Director, Clara D. Noyes, American Red Cross, Washington, D. C.

Army Nurse Corps, U. S. A.—Superintendent, Major Julia C. Stimson, War Department, Washington, D. C.

Navy Nurse Corps, U. S. N.—Superintendent, J. Beatrice Bowman, Bureau of Medicine and Surgery, Department of the Navy, Washington, D. C.

U. S. Public Health Service Nurse Corps.—Superintendent, Lucy Minnigerode, Office of the Surgeon General, U. S. Public Health Service, Washington, D. C.

Nursing Service, U. S. Veterans' Bureau.—Superintendent, Mrs. Mary A. Hickey, Hospital Section, U. S. Veterans' Bureau, Washington, D. C.

Indian Bureau.—Supervisor of Nurses, Elinor D. Gregg, Office of the Medical Director, Bureau of Indian Affairs, Dept. of the Interior, Washington, D. C.

Department of Nursing Education, Teachers College, New York.—Director, Isabel M. Stewart, Teachers College, Columbia University.

## State Associations of Nurses

Alabama.—Pres., Mattie Huston, 1319 [illegible] Ave., Mobile. Sec., Linna H. Denny, [illegible] St., Birmingham. Pres. examining board, Helen MacLean, Norwood Hospital, Birmingham. Sec., Linna H. Denny, [illegible] St., Birmingham.

Arizona.—Pres., [illegible], County Hospital, Tucson. Sec., Mrs. Martha Lea[illegible], [illegible] Apt. 5, Douglas. Pres. examining board, Mrs. Kathryn G. Hutchi-

[illegible] Tuskegee. [illegible] Minnie C. [illegible] [illegible] Church St., [illegible]

[illegible]

Colorado.—Pres., [illegible]

[illegible]

Connecticut.—[illegible]

[illegible]

Delaware.—[illegible]

[illegible]

District of Columbia.—Pres., [illegible]

[illegible] Washington.

Florida.—Pres., [illegible]

[illegible]

Georgia.—Pres., [illegible]

[illegible] Hospital, Atlanta. Sec., Lillian Cumbee, [illegible] Hosp., Atlanta. Pres., examining board, [illegible] Dorn, 1117 Telfair St., [illegible] state assn., [illegible] De Vaois, 121 Forrest Ave., Apt. [illegible] Atlanta.

[illegible] Mrs. Florence Johnson, 815 [illegible] Amack [illegible] Department of [illegible] C. A. [illegible]

[illegible] Irving [illegible] 809 S. [illegible] Pres., [illegible] Chicago. [illegible] Reese [illegible] P. B. [illegible]

[illegible] Protestant [illegible] Sec., [illegible] Evergreen Ave., [illegible] ex. [illegible] Tower, [illegible] Mrs. [illegible] University Hosp., [illegible] MacMillan, [illegible] Lutheran [illegible] Cline, [illegible]

[illegible] R. F. D. 1, [illegible] State [illegible] League [illegible] Hosp., [illegible] Frances [illegible] Council [illegible] Masonic Temple [illegible]

[illegible] Public [illegible] City Hall, Wichita. [illegible] Wichita. [illegible] Bell [illegible] Martha [illegible] Dept., [illegible] Cora A. [illegible]

[illegible] Jewish [illegible] T. C. [illegible]

[illegible] R. I. [illegible] C-4, [illegible]

[illegible] C. Mc- [illegible] New [illegible]

[illegible]

[illegible] Sec.-treas., Julia C. Tebo, 1006 [illegible] Bldg., New Orleans.

[illegible] Louise P. Hopkins, Room 9, [illegible] Sec., Mary I. Collins, [illegible] Pres. examining board, [illegible] Maine General Hospital, Port-[illegible], Mrs. Theresa R. Anderson, [illegible]

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